SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Premier Choice - Dental	SERFF Tr Num: SLIA-127053875	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 48165
Sub-TOI: H10G.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Stacy Patacsil	Disposition Date: 03/09/2011
	Date Submitted: 03/04/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 03/09/2011	
State Status Changed: 03/09/2011	Deemer Date:
Created By: Stacy Patacsil	Submitted By: Stacy Patacsil

Corresponding Filing Tracking Number:

Filing Description:

The following new forms are being submitted for your review and approval:

ERAPP.2010 - Group Application
GB207.2010 - Employee Enrollment Form
GB215.2010 - Evidence of Insurability Form
GP2010APP-AR - Acceptance Application
GP2010MP - Master Policy, Group Insurance Policy
GP2010MC - Master Certificate, Employee Certificate Provisions
GP2010MPAMEND - Master Policy Amendment

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

GP2010MCAMEND - Master Certificate Amendment

ELHERAPPDEN2-9.2010 - Dental Insurance 2 to 9 Product Addendum -
ELHERAPPDEN.2010 - Dental Insurance 10+ Product Addendum -
ELHERAPPDENDUAL.2010 - Dual Option Dental Insurance 10+ Product Addendum
ELHERAPPVDEN.2010 - Voluntary Dental Insurance Product Addendum -
ELHERAPPVDENDUAL.2010 - Voluntary Dual Option Dental Insurance Product Addendum-

GP2010DSB - Dental Schedule of Benefits
GP2010DBP - Dental Benefit Provisions

GP2010DPSB – Dental PPO Schedule of Benefits
GP2010DPBP – Dental PPO Benefit Provisions

GP2010VDSB - Voluntary Dental Schedule of Benefits
GP2010VDBP - Voluntary Dental Benefit Provisions

GP2010VDPSB – Voluntary Dental PPO Schedule of Benefits
GP2010VDPBP – Voluntary Dental PPO Benefit Provisions

The Application consists of:
• Group Application
• Applicable Addenda
• Enrollment forms for all eligible employees enrolling for coverage
• Evidence of Insurability Form, when applicable

The Policy issued to the employer will include:
• Application
• Employer Acceptance Application
• Master Policy
• Master Certificate
• Summary of Benefits and Benefit Provisions for each applicable coverage

Certificates issued to employees are comprised:
• Master Certificate
• Summary of Benefits and Benefit Provisions for each applicable coverage

The enclosed group forms provide employer-employee group insurance coverage through policies issued to employers

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

in your state. Policies are sold by licensed agents and brokers to groups.

The coverage provided includes Dental benefits on a voluntary and non-voluntary basis.

Please note that the Schedule of Benefits and any bracketed text is intended to be variable and is customized for each group policyholder.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Stacy Patacsil,	spatacsil@securitylife.com	
25 Race Ave	888-654-7100 [Phone] 5718 [Ext]	
Lancaster, PA 17608		

Filing Company Information

Security Life Insurance Company of America	CoCode: 68721	State of Domicile: Minnesota
10901 Red Circle Drive	Group Code: 492	Company Type: Life, Accident & Health
Minnetonka, MN 55343-9137	Group Name:	State ID Number:
(952) 544-2121 ext. 3589[Phone]	FEIN Number: 41-0808596	

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	Yes
Fee Explanation:	MN filing fee
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	$250.00	03/04/2011	45273636
Security Life Insurance Company of America	$800.00	03/04/2011	45281257

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/09/2011	03/09/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	03/07/2011	03/07/2011	Stacy Patacsil	03/09/2011	03/09/2011
Pending Industry Response	Rosalind Minor	03/04/2011	03/04/2011	Stacy Patacsil	03/04/2011	03/04/2011

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/09/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Employer Application	Approved-Closed	Yes
Form	Employee Enrollment Form	Approved-Closed	Yes
Form	Evidence of Insurability Form	Approved-Closed	Yes
Form	Acceptance Application	Approved-Closed	Yes
Form	Master Policy	Approved-Closed	Yes
Form	Master Certificate	Approved-Closed	Yes
Form	Master Policy Amendment	Approved-Closed	Yes
Form	Master Certificate Amendment	Approved-Closed	Yes
Form	Dental Insurance 2 to 9 Product Addendum	Approved-Closed	Yes
Form	Dental Insurance 10+ Product Addendum	Approved-Closed	Yes
Form	Dual Option Dental Insurance Product Addendum	Approved-Closed	Yes
Form	Voluntary Dental Insurance Product Addendum	Approved-Closed	Yes
Form	Voluntary Dual Option Dental Insurance Product Addendum	Approved-Closed	Yes
Form	Dental Schedule of Benefits	Approved-Closed	Yes
Form *(revised)*	Dental Benefit Provisions	Approved-Closed	Yes
Form	Dental Benefit Provisions	Replaced	Yes
Form	Dental PPO Schedule of Benefits	Approved-Closed	Yes
Form *(revised)*	Dental PPO Benefit Provisions	Approved-Closed	Yes
Form	Dental PPO Benefit Provisions	Replaced	Yes
Form	Voluntary Dental Schedule of Benefits	Approved-Closed	Yes
Form *(revised)*	Voluntary Dental Benefit Provisions	Approved-Closed	Yes
Form	Voluntary Dental Benefit Provisions	Replaced	Yes
Form	Voluntary Dental PPO Schedule of Benefits	Approved-Closed	Yes
Form *(revised)*	Voluntary PPO Benefit Provisions	Approved-Closed	Yes
Form	Voluntary PPO Benefit Provisions	Replaced	Yes

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/07/2011
Submitted Date	03/07/2011
Respond By Date	

Dear Stacy Patacsil,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment: Under the definition for Dependent and with respect to handicapped dependents, there can be no time period set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 2

- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment: Coverage for newborn infants musst be for at least 90 days as outlined under ACA 23-79-129.

Objection 3

- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment: Coverage must be provide for all minors for whom the insured has filed a petition to adopt. Refer to ACA 23-79-137. Also, refer to the 60-day period.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/09/2011
Submitted Date	03/09/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Within the Dependent definition, the language referencing the time period to furnish proof of incapacity has been deleted.

Related Objection 1

Applies To:

- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment:

Under the definition for Dependent and with respect to handicapped dependents, there can be no time period set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Dental Benefit Provisions	GP2010DBP-AR		Certificate	Initial		0.000	GP2010DBP-AR.pdf
Previous Version							
Dental Benefit Provisions	*GP2010DBP*		*Certificate*	*Initial*		*0.000*	GP2010DBP.pdf
Dental PPO Benefit	GP2010D		Certificate	Initial		0.000	GP2010D

Provisions	PBP-AR				PBP-AR.pdf
Previous Version					
Dental PPO Benefit Provisions	*GP2010D PBP*	*Certificate*	*Initial*	*0.000*	GP2010D PBP.pdf
Voluntary PPO Benefit Provisions	GP2010V DPBP-AR	Certificate	Initial	0.000	GP2010V DPBP-AR.pdf
Previous Version					
Voluntary PPO Benefit Provisions	*GP2010V DPBP*	*Certificate*	*Initial*	*0.000*	GP2010V DPBP.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Coverage for newborn infants has been revised from 31 days to 90 days.

Related Objection 1

Applies To:

- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment:

Coverage for newborn infants musst be for at least 90 days as outlined under ACA 23-79-129.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Dental Benefit Provisions	GP2010DBP-AR		Certificate	Initial		0.000	GP2010DBP-AR.pdf
Previous Version							

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Dental Benefit Provisions	*GP2010DBP*	*Certificate*	*Initial*	*0.000*	GP2010DBP.pdf
Dental PPO Benefit Provisions	GP2010DPBP-AR	Certificate	Initial	0.000	GP2010DPBP-AR.pdf
Previous Version					
Dental PPO Benefit Provisions	*GP2010DPBP*	*Certificate*	*Initial*	*0.000*	GP2010DPBP.pdf
Voluntary PPO Benefit Provisions	GP2010VDPBP-AR	Certificate	Initial	0.000	GP2010VDPBP-AR.pdf
Previous Version					
Voluntary PPO Benefit Provisions	*GP2010VDPBP*	*Certificate*	*Initial*	*0.000*	GP2010VDPBP.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: Within the definition of Child, the adopted child language has been revised to comply. Additionally, in Effective Date of your Dependent Dental Coverage, language has been added concerning adopted children.

Related Objection 1

Applies To:

- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment:

Coverage must be provide for all minors for whom the insured has filed a petition to adopt. Refer to ACA 23-79-137. Also, refer to the 60-day period.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific	Readability Score	Attach Document

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

					Data	
Dental Benefit Provisions	GP2010D BP-AR	Certificate	Initial		0.000	GP2010D BP-AR.pdf
Previous Version						
Dental Benefit Provisions	*GP2010D BP*	*Certificate*	*Initial*		*0.000*	GP2010D BP.pdf
Dental PPO Benefit Provisions	GP2010D PBP-AR	Certificate	Initial		0.000	GP2010D PBP-AR.pdf
Previous Version						
Dental PPO Benefit Provisions	*GP2010D PBP*	*Certificate*	*Initial*		*0.000*	GP2010D PBP.pdf
Voluntary Dental Benefit Provisions	GP2010V DBP-AR	Certificate	Initial		0.000	GP2010V DBP-AR.pdf
Previous Version						
Voluntary Dental Benefit Provisions	*GP2010V DBP*	*Certificate*	*Initial*		*0.000*	GP2010V DBP.pdf
Voluntary PPO Benefit Provisions	GP2010V DPBP-AR	Certificate	Initial		0.000	GP2010V DPBP-AR.pdf
Previous Version						
Voluntary PPO Benefit Provisions	*GP2010V DPBP*	*Certificate*	*Initial*		*0.000*	GP2010V DPBP.pdf

No Rate/Rule Schedule items changed.

Please note that because of the changes required, the form numbers have been revised.

Sincerely,
Stacy Patacsil

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/04/2011
Submitted Date	03/04/2011
Respond By Date	04/04/2011

Dear Stacy Patacsil,

This will acknowledge receipt of the captioned filing.

Objection 1

- Employer Application, ERAPP.2010 (Form)
- Employee Enrollment Form, GB207.2010 (Form)
- Evidence of Insurability Form, GB215.2010 (Form)
- Acceptance Application, GP2010APP-AR (Form)
- Master Policy, GP2010MP (Form)
- Master Certificate, GP2010MC (Form)
- Master Policy Amendment, GP2010MPAMEND (Form)
- Master Certificate Amendment, GP2010MCAMEND (Form)
- Dental Insurance 2 to 9 Product Addendum, ELHERAPPDEN2-9.2010 (Form)
- Dental Insurance 10+ Product Addendum, ELHERAPPDEN.2010 (Form)
- Dual Option Dental Insurance Product Addendum, ELHERAPPDENDUAL.2010 (Form)
- Voluntary Dental Insurance Product Addendum, ELHERAPPVDEN.2010 (Form)
- Voluntary Dual Option Dental Insurance Product Addendum, ELHERAPPVDENDUAL.2010 (Form)
- Dental Schedule of Benefits, GP2010DSB (Form)
- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Schedule of Benefits, GP2010DPSB (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary Dental Schedule of Benefits, GP2010VDSB (Form)
- Voluntary Dental Benefit Provisions, GP2010VDBP (Form)
- Voluntary Dental PPO Schedule of Benefits, GP2010VDPSB (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $1050.00. Please submit an additional $800.00 for this

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/04/2011
Submitted Date	03/04/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: The additional fee has been submitted.

Related Objection 1

Applies To:

- Employer Application, ERAPP.2010 (Form)
- Employee Enrollment Form, GB207.2010 (Form)
- Evidence of Insurability Form, GB215.2010 (Form)
- Acceptance Application, GP2010APP-AR (Form)
- Master Policy, GP2010MP (Form)
- Master Certificate, GP2010MC (Form)
- Master Policy Amendment, GP2010MPAMEND (Form)
- Master Certificate Amendment, GP2010MCAMEND (Form)
- Dental Insurance 2 to 9 Product Addendum, ELHERAPPDEN2-9.2010 (Form)
- Dental Insurance 10+ Product Addendum, ELHERAPPDEN.2010 (Form)
- Dual Option Dental Insurance Product Addendum, ELHERAPPDENDUAL.2010 (Form)
- Voluntary Dental Insurance Product Addendum, ELHERAPPVDEN.2010 (Form)
- Voluntary Dual Option Dental Insurance Product Addendum, ELHERAPPVDENDUAL.2010 (Form)
- Dental Schedule of Benefits, GP2010DSB (Form)
- Dental Benefit Provisions, GP2010DBP (Form)
- Dental PPO Schedule of Benefits, GP2010DPSB (Form)
- Dental PPO Benefit Provisions, GP2010DPBP (Form)
- Voluntary Dental Schedule of Benefits, GP2010VDSB (Form)
- Voluntary Dental Benefit Provisions, GP2010VDBP (Form)
- Voluntary Dental PPO Schedule of Benefits, GP2010VDPSB (Form)
- Voluntary PPO Benefit Provisions, GP2010VDPBP (Form)

Comment:

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $1050.00. Please submit an additional $800.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Stacy Patacsil

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/09/2011	ERAPP.2010	Application/Enrollment Form	Employer Application	Initial		0.000	ERAPP.2010.pdf
Approved-Closed 03/09/2011	GB207.2010	Application/Enrollment Form	Employee Enrollment Form	Initial		0.000	GB207.2010 EE SLICA.pdf
Approved-Closed 03/09/2011	GB215.2010	Application/Enrollment Form	Evidence of Insurability Form	Initial		0.000	GB215.2010 EOI SLICA.pdf
Approved-Closed 03/09/2011	GP2010APP-AR	Application/Enrollment Form	Acceptance Application	Initial		0.000	GP2010APP-AR.pdf
Approved-Closed 03/09/2011	GP2010MP	Policy/Contract/Fraternal Certificate	Master Policy	Initial		0.000	GP2010MP.pdf
Approved-Closed 03/09/2011	GP2010MC	Certificate	Master Certificate	Initial		0.000	GP2010MC.pdf
Approved-Closed 03/09/2011	GP2010MPAMEND	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Master Policy Amendment	Initial		0.000	GP2010MPAMEND.pdf
Approved-Closed 03/09/2011	GP2010MCAMEND	Certificate Amendment, Insert	Master Certificate Amendment	Initial		0.000	GP2010MCAMEND.pdf

SERFF Tracking Number:	*SLIA-127053875*			*State:*	*Arkansas*		
Filing Company:	*Security Life Insurance Company of America*			*State Tracking Number:*	*48165*		
Company Tracking Number:							
TOI:	*H10G Group Health - Dental*			*Sub-TOI:*	*H10G.000 Health - Dental*		
Product Name:	*Premier Choice - Dental*						
Project Name/Number:	*/*						
		Page, Endorsement or Rider					
Approved-Closed 03/09/2011	ELHERAPPDEN2-9.2010	Application/Enrollment Form	Dental Insurance 2 to 9 Product Addendum	Initial		0.000	ELHERAPPDEN2-9.2010.pdf
Approved-Closed 03/09/2011	ELHERAPPDEN.2010	Application/Enrollment Form	Dental Insurance 10+ Product Addendum	Initial		0.000	ELHERAPPDEN.2010.pdf
Approved-Closed 03/09/2011	ELHERAPPDENDUAL.2010	Application/Enrollment Form	Dual Option Dental Insurance Product Addendum	Initial		0.000	ELHERAPPDENDUAL.2010.pdf
Approved-Closed 03/09/2011	ELHERAPPVDEN.2010	Application/Enrollment Form	Voluntary Dental Insurance Product Addendum	Initial		0.000	ELHERAPPVDEN.2010.pdf
Approved-Closed 03/09/2011	ELHERAPPVDENDUAL.2010	Application/Enrollment Form	Voluntary Dual Option Dental Insurance Product Addendum	Initial		0.000	ELHERAPPVDENDUAL.2010.pdf
Approved-Closed 03/09/2011	GP2010DSB	Schedule Pages	Dental Schedule of Benefits	Initial		0.000	GP2010DSB.pdf
Approved-Closed 03/09/2011	GP2010DBP-AR	Certificate	Dental Benefit Provisions	Initial		0.000	GP2010DBP-AR.pdf
Approved-Closed 03/09/2011	GP2010DPSB	Schedule Pages	Dental PPO Schedule of Benefits	Initial		0.000	GP2010DPSB.pdf
Approved-Closed 03/09/2011	GP2010DPBP-AR	Certificate	Dental PPO Benefit Provisions	Initial		0.000	GP2010DPBP-AR.pdf
Approved-Closed 03/09/2011	GP2010VDSB	Schedule Pages	Voluntary Dental Schedule of Benefits	Initial		0.000	GP2010VDSB.pdf
Approved-Closed 03/09/2011	GP2010VDBP-AR	Certificate	Voluntary Dental Benefit Provisions	Initial		0.000	GP2010VDBP-AR.pdf
Approved-	GP2010VD	Schedule	Voluntary Dental	Initial		0.000	GP2010VDP

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Closed 03/09/2011	PSB	Pages	PPO Schedule of Benefits			SB.pdf
Approved-Closed 03/09/2011	GP2010VDPBP-AR	Certificate	Voluntary PPO Benefit Provisions	Initial	0.000	GP2010VDPBP-AR.pdf

Security Life
INSURANCE COMPANY OF AMERICA

GROUP APPLICATION

PLEASE PRINT CLEARLY

General Information

Employer's Full Legal Name (exactly as it will appear in the Contract):

Coverages Requested (complete and attach an addendum for each coverage selected):
❑ **Life** ❑ **STD** ❑ **LTD** ❑ **Dental** ❑ **Vision**

Business is: ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other _____

State of Incorporation: _____

Tax ID Number:	**Years in Business:**
Nature of Business:	**SIC Code:**
For groups with 2 to 9 eligible employees: **Is this a home based business?** ❑ Yes ❑ No	**For groups with 2 to 9 eligible employees:** **Are 90% or more of the employees in the same family?** ❑ Yes ❑ No

Complete Street Address:

Street _____

City _____ State _____ Zip _____ County _____

Complete Mailing Address (if different):

Street _____

City _____ State _____ Zip _____ County _____

Contact Person: **Title:**

Email:	**Telephone Number:**	**Fax Number:**

Who should receive the initial Certificates and Administration Materials?
❑ Employer—***Email required:*** _____ ❑ Producing Agent

Type of Bill Requested: ❑ List Bill ❑ Self-Administered **(Not available to groups <100 lives or groups applying for Dental or Vision)**
Billing Frequency: ❑ Monthly ❑ Quarterly **(Not available for Dental or Vision)**
Easy-Pay Method (electronic transfer of premium)**:** ❑ Yes ❑ No **If Yes, then Form# [EZPAY2008] must be completed.**

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: ❑ No ❑ Yes; if Yes, complete the following:

Subsidiary Name: _____ **Complete Street Address:** _____ _____	**Nature of Business:** ❑ Same ❑ Other _____ **Number of employees** _____
Subsidiary Name: _____ **Complete Street Address:** _____ _____	**Nature of Business:** ❑ Same ❑ Other _____ **Number of employees** _____

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit, if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Declarations

APPLICANT'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

_____ Signature of Officer or Owner	_____ Print Name of Officer or Owner	_____ Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

_____ Signature of Agent	_____ Print Name of Agent	_____ Date
Address:	Telephone #: Email:	License #:

HOME OFFICE USE:

Security Life
INSURANCE COMPANY OF AMERICA

EMPLOYEE ENROLLMENT FORM

PLEASE PRINT CLEARLY

EMPLOYER INFORMATION

Group Name:	Group Number:

TYPE OF ENROLLMENT

Please check reason for completing:

☐ New Hire ☐ Late Enrollment

☐ Rehire – Rehire Date: ____/____/____

☐ Loss of Other Coverage:

I and/or my dependents were previously covered under another group plan.

Loss of coverage was due to: Termination Date:

☐ Termination of Spouse's Employment _____/_____/_____

☐ Divorce _____/_____/_____

☐ Term./Expiration of Coverage _____/_____/_____

☐ Other - reason:_____ _____/_____/_____

EMPLOYEE INFORMATION

Name (last, first, middle):	Address (street, city, state, zip):

Social Security Number:	Class:	Regular # of Hours Worked per Week:	Income: $ ☐ Annual ☐ Hourly	Date of Hire: Full-time:____/____/____ Part-time:____/____/____	☐ Single ☐ Married

Date of Birth: ____/____/____	Gender: ☐ Male ☐ Female	Occupation:	Home Phone Number: ( ) -

Beneficiary:	Relationship:	Beneficiary Social Security #:

INSURANCE COVERAGE ELECTIONS

(Verify coverages with your employer. Select coverage by checking Yes or Waive coverage by checking No to each applicable coverage.)

EMPLOYEE	DEPENDENT(S)
Dental* ☐ Yes ☐ No	**Dependent Dental** ☐ Yes ☐ No
Life/AD&D ☐ Yes ☐ No	**Dependent Life** ☐ Yes ☐ No
Supplemental/Voluntary Life ☐ Yes $_____ ☐ No	**Supplemental/Voluntary Dependent Life** Spouse ☐ Yes $ _____ ☐ No Child ☐ Yes $ _____ ☐ No
Vision ☐ Yes ☐ No	**Dependent Vision** ☐ Yes ☐ No
STD ☐ Yes ☐ No **Voluntary STD** ☐ Yes $ _____ ☐ No	
LTD ☐ Yes ☐ No **Voluntary LTD** ☐ Yes ☐ No	

INSURANCE COVERAGE (Continued)

1. If waiving dental and/or vision coverage, please specify reason for waiving:

2. *For Voluntary Dental Coverage Only: Were you or any other person enrolling covered under voluntary dental coverage provided by this employer? ☐ Yes ☐ No If Yes, list name(s) and effective date(s) of prior voluntary dental coverage.

3. Dental Coordination of Benefits: do you or any of your dependents have other dental coverage? ☐ Yes ☐ No
If Yes, Please specify person's name, name of carrier, and policy number of other coverage.

DEPENDENT INFORMATION – COMPLETE THIS SECTION FOR EACH DEPENDENT TO BE COVERED

Full Name (first, middle, last)	Relationship	Date of Birth (mo., day, year)	Gender M/F	Social Security Number	Student** or Disabled	Coverages (refer to coverages listed on page 1)
	☐ Spouse ☐ Domestic Partner					
	Child					
	Child					
	Child					

**If a student age 19 or over, provide a current copy of full-time registration.

ACKNOWLEDGMENT (SEE NOTIFICATION STATEMENTS ON PAGE 3.)

With my signature below:

1. **I confirm I have read and understand the New Entrant Notice printed on page 3.**
2. **I confirm I have read and understand the Fraud Statements printed on page 3.**
3. **I understand that I must authorize deduction from my wages for my portion, if any, of the premium.**
4. **When this insurance becomes effective, I authorize deduction from my wages to pay my portion, if any, of the premium.**
5. **I hereby state the statements are true and have been completed to the best of my knowledge and belief.**

Date: _____/_____/_____ Signature: _____

Home Office Use Only:

NEW ENTRANT NOTICE (Only applicable to Disability Coverage)

If you have received medical care or advice within the 90 days preceding your original effective date for an illness or physical condition, you may not be covered for that illness or physical condition for up to one year under this plan. This exclusion applies only to an illness or physical condition for which medical care or advice has been received within the 90 days preceding your original effective date. Please consult your certificate of coverage for specific information regarding the preexisting condition exclusion that applies to you. "New Entrant" is any individual who was not covered under this employer's previous plan(s) for the past 12 months.

FRAUD STATEMENT

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Security Life
INSURANCE COMPANY OF AMERICA

EVIDENCE OF INSURABILITY FORM

PLEASE PRINT CLEARLY

☐ LATE ENTRANT ☐ OTHER ENROLLMENT

Group Name:	Group Number:

EMPLOYEE INFORMATION

Name (last, first, middle):	Address (street, city, state, zip):	Residence Phone Number: ( )

Social Security Number:	Class:	Regular # of Hours Worked per Week:	Income: $ ☐ Annual ☐ Hourly	Date of Hire: Full-time:_____/_____/____ Part-time:_____/_____/____	☐ Single ☐ Married

Date of Birth: _____/_____/____	Gender: ☐ Male ☐ Female	**Height (Required):**	**Weight (Required):**	Occupation:

DEPENDENT INFORMATION – COMPLETE THIS SECTION FOR EACH DEPENDENT TO BE COVERED

Full Name (first, middle, last)	Relationship	Date of Birth (mo., day, year)	Gender M/F	Height (Required)	Weight (Required)	Social Security Number
	☐ Spouse ☐ Domestic Partner					
	Child					
	Child					
	Child					

MEDICAL QUESTIONS: For you or any listed dependent(s) (For any "Yes" answers fill in the details on page 2 — Additional Health Information.)	**Employee** Yes	No	**Spouse** Yes	No	**Child** Yes	No
1. In the past 7 years, been medically advised of or treated for heart attack, heart murmur, stroke, chest pain, high blood pressure, high cholesterol, anemia, varicose veins or other disorders of the heart, blood, or blood vessels ?	☐	☐	☐	☐	☐	☐
2. In the past 7 years, been medically advised of or treated for diabetes, kidney or bladder disease, sugar or blood in urine, disorder of reproductive organs, arthritis, back trouble, lung, allergies, asthma or respiratory disease?	☐	☐	☐	☐	☐	☐
3. Been medically advised of or treated, at any time, for cancer, tumor, cyst, growth or abnormal mole?	☐	☐	☐	☐	☐	☐
4. In the past 7 years, been medically advised of or treated for dizziness, fainting spells, convulsions, epilepsy, paralysis, numbness, multiple sclerosis, a neurological disorder or disease, persistent headaches, stress, anxiety, depression or any other mental illness?	☐	☐	☐	☐	☐	☐
5. Within 10 years ever used drugs other than as prescribed by a physician; been advised to have treatment or been treated for drug abuse or alcoholism?	☐	☐	☐	☐	☐	☐
6. Are you or any of your dependents currently pregnant? If yes, list due date: Mo. _____ Day _____ Yr. _____ Any complications? ☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
7. Are you or any of your dependents currently disabled, have a physical or mental impairment, or are under a doctor's care, other than listed on this application?	☐	☐	☐	☐	☐	☐
8. In the past 12 months, been advised to have any medical diagnostic testing or treatment that has not yet been completed or performed?	☐	☐	☐	☐	☐	☐
9. Been medically advised of or treated, at any time, for acquired immune deficiency syndrome (AIDS), aids related complex (ARC), human immune deficiency virus (HIV), enlargement of lymph nodes, chronic diarrhea, unexplained infections, weight loss or any other immunological disorder?	☐	☐	☐	☐	☐	☐
10. In the past 12 months taken any prescribed medications?	☐	☐	☐	☐	☐	☐

Group Name:	Group Number:

ADDITIONAL HEALTH INFORMATION: SPECIFY BY NAME IF INFORMATION IS FOR EMPLOYEE, SPOUSE OR CHILD.

Ques. No.	First Name	Description of illness, injury or pregnancy, medication and treatment	Duration (dates) & number of episodes	Name and address of attending physician, hospital or pharmacy (including zip)

ACKNOWLEDGMENT (SEE NOTIFICATION STATEMENTS ON THE PAGE 3)

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization or person that has any records or knowledge of me or my health, or that of my family, to give Security Life Insurance Company of America, or its authorized representative, any such information so that eligibility of coverage can be determined. A copy of this authorization shall be as valid as the original, shall be as valid for 24 months from the date below for the purpose of collecting information for this application, and shall be valid for the term of coverage for the purpose of collecting information in connection with a claim for benefits. I, or a person authorized to act on my behalf, am entitled to receive a copy of the authorization form and may revoke the authorization form at any time by written notification to Security Life Insurance Company of America at its home office.
2. With my signature below, I confirm I have read and understand the New Entrant Notice, applicable Fraud Statement printed on page 3 and Medical Information Notice on page 4.
3. When this insurance becomes effective, I understand I must authorize deduction from my wages to pay my portion, if any, of the premium.
4. I hereby state the statements are true and have been completed to the best of my knowledge and belief.

Date: _____/_____/_____	Signature: _____
For Home Office Use Only:	Print Name: _____

NEW ENTRANT NOTICE (Only applicable to Disability Coverage)

If you have received medical care or advice within the 90 days preceding your original effective date for an illness or physical condition, you may not be covered for that illness or physical condition for up to one year under this plan. This exclusion applies only to an illness or physical condition for which medical care or advice has been received within the 90 days preceding your original effective date. Please consult your certificate of coverage for specific information regarding the preexisting condition exclusion that applies to you. "New Entrant" is any individual who was not covered under this employer's previous plan(s) for the past 12 months.

FRAUD STATEMENT

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FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

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FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MEDICAL INFORMATION NOTICE
IT IS REQUIRED THAT YOU BE GIVEN THIS NOTICE. PLEASE READ IT CAREFULLY AND KEEP A COPY FOR YOUR RECORDS.

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, which is a member of the Medical Information Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may reveal this information, as necessary, to a doctor, if we find a serious health problem which you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instruction on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If this information came from the Medical Information Bureau and you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 102, Essex Station, Boston Massachusetts 02112, (617) 426-3660.

APPLICATION IS MADE TO

SECURITY LIFE INSURANCE COMPANY OF AMERICA

Home Office: [Lancaster], Pennsylvania

BY

[JOE'S LANDSCAPING SERVICE, INC.]

For Group Policy No. [0000012345]

By this application, the policy numbered above is approved and its terms are accepted. This application replaces any application for the policy with an earlier date.

Dated at: [Any Address} on: [March, 31, 2011]

Accepted for the policyholder by the following authorized representative:

[Joe Owner]
(signature)

[President]
(title)

Please Sign the Application and return the loose copy to Security Life Insurance Company of America at [P.O. Box 83149, Lancaster], Pennsylvania [17608-3149].

FRAUD STATEMENT:
Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

GROUP INSURANCE POLICY

Policyholder: [Joe's Landscaping Service, Inc.] **Policy No:** [0000012345]

Effective Date: [11/01/2010]

State of Issue: [PA]

Covered Employer: The policyholder and these named subsidiaries and/or affiliates:

[None]

Coverages Provided: [Life, Voluntary Life, Short Term Disability, Voluntary Short Term Disability, Long Term Disability, Voluntary Long Term Disability, Dental, Voluntary Dental, Vision, Voluntary Vision]

"We," "Us" or "Our" Defined: "We," "us" or "our" means Security Life Insurance of America.

Policy Issue and Effective Date: This policy is issued in consideration of the payment of premiums when due. We have issued the policy to the policyholder and will pay the stated benefits subject to all the terms of the policy. The policy takes effect as of the Effective Date if the first premium due has been paid to us.

Policy Anniversaries: Coverage under the policy is annually renewable.

Policy Terms: The terms shown on this and the attached pages are all a part of the policy.

Issue and Delivery: The policy has been issued for delivery in the state of issue shown above and will be governed by its laws.

Rate Guarantee Period: Except as provided in Changes to Premium Rates during the Rate Guarantee Period, we will not change the premium rates for the policyholder's coverage for the number of months following the Coverage Effective Date as shown in the chart below.

Coverage	Coverage Effective Date	Rate Guarantee Period
[Voluntary] [Life]	[11/01/2010]	[24 Months]
[Voluntary] [Short Term Disability]	[11/01/2010]	[24 Months]
[Voluntary] [Long Term Disability]	[11/01/2010]	[24 Months]
[Voluntary] [Dental]	[11/01/2010]	[12 Months]
[Voluntary] [Vision]	[11/01/2010]	[12 Months]

READ THIS POLICY CAREFULLY

/ S / ***/ S /***

President **Secretary**

Security Life Insurance Company of America
[25 Race Avenue P.O. Box 83149]
[Lancaster], Pennsylvania [17608-3149]
[(717) 397-2751 / (800) 233-0307]

TABLE OF CONTENTS

POLICY PROVISIONS

Changes in Policy

From the Effective Date of this policy, changes in the following items will automatically be made part of the policy:

1. the name of the policyholder or covered employer; and
2. the premium rates; and
3. amounts of insurance, eligibility, benefit descriptions, or any other provisions incorporated into this policy.

Effective Date of Changes

The effective date of any provision or any other change that affects the insurance of any person covered under this policy shall be the later of:

1. the Effective Date of this policy; or
2. the date of any amendment to this policy that modifies our obligation to pay benefits under this policy.

Policy

All of the benefits and provisions in the certificate of insurance issued under this policy are included in and made a part of this policy.

GENERAL PROVISIONS

Certificates
We will deliver a certificate of insurance to the policyholder for delivery to each employee who becomes insured under this policy. The certificate will state the essential features of the employee's insurance.

Entire Contract
This policy, including the certificate of insurance and the policyholder's application attached to this policy, and any amendments to this policy, constitute the entire contract of insurance.

Changes
The terms of this policy may be modified or waived only by a written agreement signed by an officer of Security Life Insurance Company of America, including, but not limited to, the President and Secretary.

This authority cannot be delegated. No agent has any authority to change this policy or to waive any of its provisions.

Statements
Absent fraud, all statements by the policyholder are representations and not warranties. No statement by the policyholder will alter the contract unless that statement is part of the contract.

Contestability of Coverage
The validity of the policy will not be contested, except for nonpayment of premiums, after two years from its Effective Date. This does not preclude the assertion at any time of defenses based on ineligibility for coverage under this policy.

Conformity with Law
Any provision of this policy that, on its effective date, is contrary to any law to which it is subject, is amended to conform to the minimum requirements of such law.

New Entrants
All new eligible employees of the policyholder and eligible dependents of those employees will become insured when they satisfy the requirements set forth in the certificate of insurance.

Ownership
The policyholder is the owner of the policy and may agree with us to change it without the consent of the covered persons or their assignees. However, no change may affect in any way:

1. the right to change a beneficiary; or
2. the right to exercise any applicable conversion privilege.

Records; Essential Data
1. The policyholder will keep a record of all covered persons. This record will contain all the data specified by us to administer the terms of the policy and set premium rates. The following information must be provided to us as changes occur:

    a. information about employees (dependents if applicable)
        - who are eligible to become insured,
        - whose coverage ends,
        - who have earning changes that affect income based benefits,
        - whose status changes; and

    b. occupational information and any other information that may be required to manage a claim; and
    c. any other information that may be reasonably required.

2. We have a right to inspect all records of the policyholder that relate to the insurance that is the subject of this policy. These records must be open for inspection at any reasonable time.

2. Clerical errors or omissions will not:
    a. deprive an eligible person of insurance;
    b. affect a covered person's amount of insurance; or
    c. continue a person's insurance or provide a person with insurance that otherwise would not be in force.

    An adjustment of premium will be made to correct the error or omission. Adjustments that reduce the premium payable will be made for a period no longer than one year.

Misstatements
If an employee's age, health history, or other important data is misstated, the records will be changed to show the correct information. If the change affects the premium rate used to calculate the premium, the premium rate will be changed and any premium due will be based on the correct rate.

Limit of Our Liability
Our liabilities are limited to those shown in the provisions of this policy.

Effect of Policyholder Actions
The policyholder will act for and on behalf of all covered employees in matters relating to this policy. Every act done by, agreement made with, and notice given to the policyholder will be binding on the covered employees.

Workers' Compensation
This policy is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

PREMIUMS AND GRACE PERIOD

Premium Due Dates
The first premium is due on the Effective Date and subsequent premiums will be due on the same day of every month thereafter, or on such other day as agreed to by us.

Premium Payments for Covered Persons
A period of premium charge for each covered person will begin on:

1. the effective date of coverage for that covered person; or
2. the effective date of a change in the coverage; or
3. the first day of a premium due date for all other premium changes.

Period of Premium Charge
A premium charge will be made for whole policy months only except, when coverage for a policyholder or any covered person becomes effective, changes or terminates on other than a premium due date, premium will be prorated to the next premium due date.

Premium Computation
The premium due is the sum of the premiums for the current period and the premium adjustments for prior periods. Premium due for the current Period of Premium Charge is the product of (a) the premium rate in effect; and (b) the number of units covered at the beginning of the current period. If there are different rate classes for a coverage, the product of (a) and (b) above will be calculated for each class. The sum of those products will be the premium due for that coverage.

Changes to Premium Rates during the Rate Guarantee Period
We may, prior to the end of the Rate Guarantee Period, change the premium rates under the policy, as follows:

1. on the date appropriate when due to misstatement of age or other data used by us to calculate premium; or
2. on the effective date of any change in the benefit provisions; or
3. on the date appropriate when due to a change in the number of insured employees or volume of insurance of more than [15]%; or
4. on the effective date of an acquisition or merger if the policyholder acquires or merges with an unrelated business; or
5. on or after the effective date of a change to any applicable Local, State or Federal tax.

Changes to Premium Rates after the Rate Guarantee Period
After the end of the Rate Guarantee Period, we may change the premium rates as follows:

1. on any premium due date; or
2. at any other time after notifying the policyholder in writing at least 31 days in advance; or on an earlier date if agreed to by us and the policyholder.

Changes to Premium due to Misstatements
There may be a charge to the policyholder or refund from us to adjust past premium payments based on a misstatement of age or other data used to calculate premium. This charge or refund will be equal to the difference between: (a) premiums previously billed and paid; and (b) the premiums that, based on the most current data, should have been billed and paid. Premium changes that result in a refund to the policyholder will be made for a period no longer than one year.

Grace Period
A grace period of 31 days measured from the premium due date will be allowed for payment of each premium due after the first premium. The insurance will remain in force during the grace period, as long as premiums are paid. The policyholder may be liable to us for all unpaid premiums for any period, including the grace period, during which coverage under the policy was in force as to any covered person.

.

POLICY TERMINATION

Termination by Policyholder

The policyholder may terminate the coverage provided under this policy on any Premium Due Date. Written notice of termination must be given to us at least 31 days before the date this policy is to end. Termination will not become effective during any premium period for which a premium has been paid to us.

Automatic Termination

Coverage under the policy will terminate for any policyholder as of the date the unpaid premium was due.

Termination by Us

We may terminate the coverage of any policyholder on the date indicated in a written notice for any of the following reasons:

1. fraud or misrepresentation of the policyholder;
2. violation of our participation, eligible lives or contribution rules;
3. if we no longer provide the applicable group coverage in the market where the policyholder is located.

We may terminate the coverage of any policyholder for any other reason after giving the policyholder at least 31 days prior written notice.

Effect of Termination

If this policy terminates, the policyholder may be liable to us for all unpaid premiums for any period, including the grace period, during which this policy was in force.

Termination shall be without prejudice to any claim for benefits provided by this policy that originate prior to the effective date of termination.

CERTIFICATE

issued by

SECURITY LIFE INSURANCE COMPANY OF AMERICA

We certify that we have issued the policy numbered below. This certificate is a part of the policy. The policy is part of the contract between the policyholder and us. The contract is made up of:

1. the policy; and

2. the policyholder's application attached to the policy.

Insurance coverage under the policy will become effective only if you fulfill all requirements, including any eligibility requirements, necessary to become and remain insured by the terms of the policy.

READ THIS CERTIFICATE CAREFULLY

POLICYHOLDER: [Joe's Landscaping Service, Inc.]

GROUP POLICY NUMBER: [0000012345]

EFFECTIVE DATE OF POLICY: [11/01/2010]

/ S / ***/ S /***

President **Secretary**

Security Life Insurance Company of America
[25 Race Avenue P.O. Box 83149]
[Lancaster], Pennsylvania [17608-3149]
[(717) 397-2751 / (800) 233-0307]

Table of Contents

Introduction

Welcome to Security Life Insurance Company of America! This certificate explains **your** insurance benefits. Please read it carefully as it contains important information about **your** insurance **coverage**.

Your certificate has been organized into several sections, with designated sections that apply to all **coverages** as well as sections that apply to each specific **coverage**.

Typically**, you** will find:

1. A General Terms section, which defines terms that apply to all **coverages**;
2. A General Provision section, which applies to all **coverages**; and
3. For each specific **coverage** provided:
    a. A Schedule of Benefits;
    b. A Defined Terms section;
    c. A Coverage section, which provides details about how and when the **coverage** applies;
    d. A Benefit section;
    e. A Limitations and Exclusions section; and
    f. A Claims Provision section.

As **you** read through **your** certificate, **you** will notice bolded words, which indicate terms that have been defined by **us** in the certificate. These definitions can be found in either the General Terms section, which applies to all **coverages,** or in the Defined Terms section for the specific **coverage** to which they apply. It is very important that **you** refer to these definitions as **you** read the certificate to make sure **you** understand **your** benefits clearly.

Please keep this certificate (and any updates or changes) as long as **you** are [employed by **your** employer and] covered under the **policy**. Refer to the certificate whenever **you** have a question about **your** insurance. If **you** have any questions about **your** insurance, **you** can ask **your** employer's insurance administrator, call **us** at [(717) 397-2751 or (800) 233-0307], or visit **our** website at [www.securitylifeinsurance.com]. **We** are happy to help **you** in any way **we** can to understand the terms of this certificate.

Thank **you** for **your** trust and confidence in Security Life Insurance Company of America.

IMPORTANT INFORMATION

Certain events may impact **your coverage** or **our** ability to pay **your** claims promptly. Therefore, it is important that **you** notify **us** immediately if:

1. **You** change **your** name; or
2. **You** change **your** address.

[You should notify **your** employer if:

1. [**You** have or adopt a child, or when **your** child is no longer eligible for **our coverage** (if **you** have dependent child or family **coverage**)][;or]
2. [**You** divorce **your** spouse (if **you** have dependent spouse or family **coverage)**][;or]
3. [**You** become disabled, or **you** return to work following a period of disability]].

General Terms

Active Employee

A person who is a citizen or legal resident of the United States or Canada and **actively at work** with the **covered employer. You** must be performing all of the duties of **your** job with a **covered employer** on a full-time basis. This job may be at either:

1. the **covered employer's** normal place of employment; or
2. at some other place to which the regular business operations of the **covered employer** require **you** to travel.

Full-time means **you** must:

1. regularly work for the **covered employer** the number of work hours required for eligibility as shown in the Schedule of Benefits; and
2. be on the regular payroll of the **covered employer** for that work.

Active Work

Work **you** perform as an **active employee**.

Actively at Work

Being engaged in **active work**.

Calendar Year

January 1 through December 31 of the same year.

Coverage

Any type of insurance specified. The specific type of insurance is identified at the top of the Schedule of Benefits and corresponding sections.

Under the **policy**, **coverages** include [Voluntary][Life Insurance][,][Short Term Disability Insurance][,][Long Term Disability Insurance][,][Vision Insurance][and][Dental Insurance].

Covered Employer

The policyholder and its subsidiaries and/or affiliates, as named in the **policy**.

Covered Person

Any person who is insured under the **policy.**

Eligibility Date

The date that **you** satisfy the Eligibility Requirement. [**Your** dependent's **eligibility date** is the date that **your** dependent satisfies the Eligibility Requirement for your Dependent Coverage.]

Eligible Class

Any designated group of employees of the **covered employer** that can be insured under the **policy** as shown in the Schedule of Benefits for each **coverage**.

Our Home Office	[25 Race Avenue, PO Box 83149, Lancaster], PA [17608-3149] Telephone Number: [(717) 397-2751 or (800) 233-0307] [Email Address: www.securitylifeinsurance.com]
Policy	Part of the contract between the policyholder and **us**. The certificate is a part of the **policy**.
We, Us, or Our	Security Life Insurance Company of America.
You or Your	An insured employee
[Waiting Period	The amount of time **you** must be employed by the **covered employer** as shown in the Schedule of Benefits for each **coverage**. **You** must be in continuous **active work** in an **eligible class** during the specified **waiting period** before **your coverage** can become effective.]

Statements Made by you

All statements made by **you,** in the absence of fraud, are representations and not warranties. No statement by any **covered person** will alter the insurance or reduce benefits, unless the statement is contained in a written document signed by the **covered person**, and a copy of which has been furnished to **you** or **your** beneficiary by **us**. [For life insurance only, the insurance must have been in effect for less than two years.]

Inspection of the Policy

A copy of the **policy** is on file at the office of the policyholder.

Physical Examination and Autopsy

At **our** expense, **we** have the right to require a physical examination, by a specialist of **our** choice, on any **covered person** as often as reasonably necessary while a claim is pending. At **our** expense, **we** may also require an autopsy, unless prohibited by law.

[We may suspend or deny [short] [or] [long] term disability benefits if **you** fail to attend an examination or cooperate with the examiner.]

Interpretation of the Policy

We shall have the authority, in **our** sole discretion, to construe the terms of the **policy** and to determine benefit eligibility thereunder. **Our** decisions regarding the construction of the terms of the **policy** and benefit eligibility shall be conclusive and binding.

References to Time

All references to time shall mean the time at the principal place of business of the policyholder. All periods affecting the **policy** begin at 12:00 a.m. and end at 11:59 p.m., standard time, at the policyholder's principal place of business.

POLICY AMENDMENT

Policyholder: [ABC Company]
Policy Number: [12345]

Amendment # [1]:

Effective [03/01/2011], the Policy is amended as follows:

[This change only applies to [disabilities which begin][or][claims incurred] on or after the effective date of this Amendment.]
[These changes only apply to [disabilities which begin][or][claims incurred] on or after the effective date of this Amendment.]

Nothing contained in this Amendment will be held to alter or affect any of the terms and conditions of the Policy other than as stated above.

/ S / ***/ S /***

President **Secretary**

Security Life Insurance Company of America
[25 Race Avenue P.O. Box 83149]
[Lancaster,] Pennsylvania [17608-3149]
[(717) 397-2751 / (800) 233-0307]

GP2010MPAMEND

CERTIFICATE AMENDMENT

Policyholder: [ABC Company]
Policy Number: [12345]

[Amendment # [1]:]

Effective [03/01/2011] Your Certificate is amended as follows:

[The [Life Insurance] [Dental Insurance] [Short Term Disability] [Long Term Disability] [Vision] provisions of the Policy are changed as follows:]

[This change only applies to [disabilities which begin][or] [claims incurred] on or after the effective date of this Amendment.]
[These changes only apply to [disabilities which begin][or] [claims incurred] on or after the effective date of this Amendment.]

Nothing contained in this Amendment will be held to alter or affect any of the terms and conditions of the Certificate other than as stated above.

/ S / ***/ S /***

President **Secretary**

Security Life Insurance Company of America
[25 Race Avenue P.O. Box 83149]
[Lancaster], Pennsylvania [17608-3149]
[(717) 397-2751 / (800) 233-0307]

GP2010MCAMEND

Security Life Insurance Company of America
Dental Insurance 2 to 9 Product Addendum

Group Information

Name of Employer: | **Requested Effective Date:**

Number of Eligible Employees: | **Number of Employees Enrolling:**

Do you currently have Group Dental Insurance? ❑ No ❑ Yes **Current Carrier:**
(If yes, attach a copy of the certificate and the latest billing statement.)

Termination of Coverage will occur on: ❑ the date the employee is no longer actively at work
❑ the end of the month in which the employee is no longer actively at work

Coverage Information

Class Description:

Weekly Work Hours Required for Eligibility (min. 30 hours):

Does Employee Contribute? ❑ Yes ❑ No

If "Yes," **Amount EMPLOYEE Contributes:** _____% for employee coverage (max. 75% employee contribution)

Dependent Dental: ❑ Yes ❑ No If "Yes," **Amount EMPLOYEE Contributes:** _____% for dependent coverage

Eligibility Waiting Period (minimum 30 days)**:**

❑ _____ days from date of hire ❑ First of month following _____ days from date of hire

Do you want to include VSP Vision Access Discount Program at no charge? ❑ Yes ❑ No

Plan Information

❑ Indemnity ❑ PPO (where available)

Benefit Percentages:

Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:
❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:
❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**
❑ $25 Calendar Year ❑ $50 Calendar Year ❑ Other $_____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ Other $_____

Waiting Periods for Major Expenses:
Do you currently have Major coverage? ❑ Yes (a one year wait applies for new hires only)
❑ No (a one year wait applies for current employees and new hires)

Security Life Insurance Company of America
Dental Insurance 2 to 9 Product Addendum

Plan Information-Continued

Additional Benefit Options:

Cleanings: ❑ Standard — 1 routine cleaning *or* 1 periodontal maintenance every 6 months

❑ Buy-up Additional — 1 routine cleaning *and* 1 periodontal maintenance every 6 months

Implant Coverage (Major Only)**:** ❑ Yes ❑ No

Do Preventive expenses apply toward the annual maximum? ❑ Yes ❑ No

Annual Maximum Rollover Benefit: ❑ Yes ❑ No

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? ❑ Yes ❑ No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

I understand that a late entrant restriction applies to employees and their dependents who enroll for coverage after 31 days in which they were first eligible. As such my plan does not have an annual open enrollment period.

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

_____ _____

Signature of Officer or Owner **Date**

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Security Life Insurance Company of America
Dental Insurance 10+ Product Addendum

Group Information

Name of Employer: | **Requested Effective Date:**

Number of Eligible Employees: | **Number of Employees Enrolling:**

Do you currently have Group Dental Insurance? ❑ No ❑ Yes **Current Carrier:**
(If yes, attach a copy of the certificate and the latest billing statement.)

Number of COBRA Employees Enrolling: _____
(Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)

Does your plan require an Annual Open Enrollment? ❑ No ❑ Yes Annual open enrollment will occur during the month preceding the renewal date.

Termination of Coverage will occur on:
❑ the date the employee is no longer actively at work
❑ the end of the month in which the employee is no longer actively at work

Coverage Information

Class Description: | **Weekly Work Hours Required for Eligibility:**

Does Employee Contribute? ❑ Yes ❑ No

If "Yes," **Amount EMPLOYEE Contributes:** _____% for employee coverage

Dependent Dental: ❑ Yes ❑ No If "Yes," **Amount EMPLOYEE Contributes:** ___% for dependent coverage

Eligibility Waiting Period:

❑ _____ days from date of hire ❑ First of month following _____ days from date of hire

Do you want to include VSP Vision Access Discount Program at no charge? ❑ Yes ❑ No

Plan Information

❑ Indemnity ❑ PPO (where available)

Benefit Percentages:

Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:
❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:
❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**

❑ $0 Calendar Year ❑ $25 Calendar Year ❑ $50 Calendar Year ❑ $100 Lifetime ❑ Other $_____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Dental Insurance 10+ Product Addendum

Plan Information (Continued)

Waiting Periods for Major Expenses:
Do you currently have Major Coverage?

❑ Yes ❑ No If "No", is a one-year wait for current employees to be applied? ❑ Yes ❑ No

Is a one-year wait for new hires to be applied? ❑ Yes ❑ No

Additional Benefit Options:

Cleanings: ❑ Standard — 1 routine cleaning *or* 1 periodontal maintenance every 6 months
❑ Buy-up Additional — 1 routine cleaning *and* 1 periodontal maintenance every 6 months

Implant Coverage (Major Only): ❑ Yes ❑ No

Do Preventive expenses apply toward the annual maximum? ❑ Yes ❑ No

Annual Maximum Rollover Benefit: ❑ Yes ❑ No

Orthodontia Option:
❑ Yes, Child Only ❑ Yes, Child & Adult ❑ No

Orthodontia Benefit Percentage:

Indemnity/In-Network ❑ 50% ❑ 60% ❑ Other _____%

Out-of-Network ❑ 50% ❑ 60% ❑ Other _____%

Orthodontia Lifetime Maximum: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Waiting Periods for Orthodontia Expenses:
Do you currently have Orthodontia coverage?
❑ No (a one-year wait applies for current employees and new hires.)
❑ Yes If "Yes," is a one-year wait for new hires to be applied? ❑ Yes ❑ No

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? ❑ Yes ❑ No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Dental Insurance 10+ Product Addendum

Declaration

I understand that employees and their dependents who enroll for coverage after 31 days in which they were first eligible must satisfy waiting periods before they become eligible for certain types of services.

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner	Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Security Life Insurance Company of America
Dual Option Dental Insurance 10+ Product Addendum

Group Information

Name of Employer: **Requested Effective Date:**

Number of Eligible Employees: **Number of Employees Enrolling:**

Do you currently have Group Dental Insurance? ❑ No ❑ Yes **Current Carrier:**
(If yes, attach a copy of the certificate and the latest billing statement.)

Number of COBRA Employees Enrolling: _____
(Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)

Does your plan require an Annual Open Enrollment? ❑ No ❑ Yes Annual open enrollment will occur during the month preceding the renewal date.

Termination of Coverage will occur on: ❑ the date the employee is no longer actively at work
❑ the end of the month in which the employee is no longer actively at work

Coverage Information

Class Description: **Weekly Work Hours Required for Eligibility:**

Eligibility Waiting Period:
❑ _____ days from date of hire ❑ First of month following _____ days from date of hire

Do you want to include VSP Vision Access Discount Program at no charge? ❑ Yes ❑ No

LOW Option:

Does Employee Contribute? ❑ Yes ❑ No

If "Yes," **Amount EMPLOYEE Contributes:** _____% for employee coverage

Dependent Dental: ❑ Yes ❑ No If "Yes," **Amount EMPLOYEE Contributes:** _____% for dependent coverage

HIGH Option:

Does Employee Contribute? ❑ Yes ❑ No

If "Yes," **Amount EMPLOYEE Contributes:** _____% for employee coverage

Dependent Dental: ❑ Yes ❑ No If "Yes," **Amount EMPLOYEE Contributes:** _____% for dependent coverage

Dual Option Dental Insurance 10+ Product Addendum

Plan Information

❑ Indemnity ❑ PPO (where available)

SECTION I Complete for Dual **Low** Option benefit information

Benefit Percentages:

Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:
❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:
❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**
❑ $0 Calendar Year ❑ $25 Calendar Year ❑ $50 Calendar Year ❑ $100 Lifetime ❑ Other $_____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Waiting Periods for Major Expenses:
Do you currently have Major Coverage?
❑ Yes ❑ No If "No", is a one-year wait for current employees to be applied? ❑ Yes ❑ No

Is a one-year wait for new hires to be applied? ❑ Yes ❑ No

Orthodontia Option:
❑ Yes, Child Only ❑ Yes, Child & Adult ❑ No

Orthodontia Benefit Percentage:

Indemnity/In-Network ❑ 50% ❑ 60% ❑ Other _____%

Out-of-Network ❑ 50% ❑ 60% ❑ Other _____%

Orthodontia Lifetime Maximum: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Waiting Periods for Orthodontia Expenses:
Do you currently have Orthodontia coverage?
❑ No (a one-year wait applies for current employees and new hires.)
❑ Yes If "Yes," is a one-year wait for new hires to be applied? ❑ Yes ❑ No

Dual Option Dental Insurance 10+ Product Addendum

SECTION II Complete for Dual **High** Option benefit information

Benefit Percentages:

Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:
❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:
❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**
❑ $0 Calendar Year ❑ $25 Calendar Year ❑ $50 Calendar Year ❑ $100 Lifetime ❑ Other $_____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Waiting Periods for Major Expenses:
Do you currently have Major Coverage?
❑ Yes ❑ No If "No", is a one-year wait for current employees to be applied? ❑ Yes ❑ No
Is a one-year wait for new hires to be applied? ❑ Yes ❑ No

Orthodontia Option:
❑ Yes, Child Only ❑ Yes, Child & Adult ❑ No

Orthodontia Benefit Percentage:

Indemnity/In-Network ❑ 50% ❑ 60% ❑ Other _____%

Out-of-Network ❑ 50% ❑ 60% ❑ Other _____%

Orthodontia Lifetime Maximum: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Waiting Periods for Orthodontia Expenses:
Do you currently have Orthodontia coverage?
❑ No (a one-year wait applies for current employees and new hires.)
❑ Yes If "Yes," is a one-year wait for new hires to be applied? ❑ Yes ❑ No

SECTION III Additional Benefit Options

Cleanings: ❑ Standard — 1 routine cleaning *or* 1 periodontal maintenance every 6 months
❑ Buy-up Additional — 1 routine cleaning *and* 1 periodontal maintenance every 6 months

Implant Coverage (Major Only)**:** ❑ Yes ❑ No

Do Preventive expenses apply toward the annual maximum? ❑ Yes ❑ No

Dual Option Dental Insurance 10+ Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? ❑ Yes ❑ No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

I understand that employees and their dependents who enroll for coverage after 31 days in which they were first eligible must satisfy waiting periods before they become eligible for certain types of services.

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

_____ _____

Signature of Officer or Owner **Date**

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Security Life Insurance Company of America
Voluntary Dental Insurance Product Addendum

Group Information

Name of Employer: **Requested Effective Date:**

Number of Eligible Employees: **Number of Employees Enrolling:**

Do you currently have Group Dental Insurance? ❑ No ❑ Yes **Current Carrier:**
(If "yes," attach a copy of the certificate and the latest billing statement.)

Number of COBRA Employees Enrolling: _____
(Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)

Open Enrollment Date: Annual open enrollment will occur during the month preceding the renewal date.

Termination of Coverage will occur on: ❑ the date the employee is no longer actively at work
❑ the end of the month in which the employee is no longer actively at work

Coverage Information

Class Description: **Weekly Work Hours Required for Eligibility:**

Dependent Dental: ❑ Yes ❑ No

Eligibility Waiting Period:

❑ _____ days from date of hire ❑ First of month following _____ days from date of hire

Do you want to include VSP Vision Access Discount Program at no charge? ❑ Yes ❑ No

Plan Information

❑ Indemnity ❑ PPO (where available)

Benefit Percentages:
Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:
❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:
❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**
❑ $25 Calendar Year ❑ $50 Calendar Year ❑ $100 Lifetime ❑ Other $_____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Voluntary Dental Insurance Product Addendum

Basic Waiting Periods:

Under 20 Eligible Lives, a 6-month wait will apply to current employees* and new hires.

20+ Eligible Lives (select one):

- ❑ 6-month wait applies to current employees* and new hires
- ❑ 6-month wait waived for current employees; 6-month wait applies to new hires
- ❑ 6-month wait waived for current employees and new hires

6-month standard wait will apply with Open Enrollment.

Major Waiting Periods:

Under 50 Eligible Lives, a 12-month wait will apply to current employees* and new hires.

50+ Eligible Lives (select one):

Major Services

- ❑ 12-month wait applies to current employees* and new hires
- ❑ 12-month wait waived for current employees; 12-month wait applies to new hires
- ❑ 12-month wait waived for current employees and new hires

12-month standard wait will apply with Open Enrollment.

Additional Benefit Options:

Cleanings: ❑ Standard — 1 routine cleaning *or* 1 periodontal maintenance every 6 months
❑ Buy-up Additional — 1 routine cleaning *and* 1 periodontal maintenance every 6 months

Implant Coverage (Major Only): ❑ Yes ❑ No

Do Preventive expenses apply toward the annual maximum? ❑ Yes ❑ No

Annual Maximum Rollover Benefit: ❑ Yes ❑ No

Orthodontia Option (available for groups with 50+ eligible lives):

❑ Yes, Child Only ❑ Yes, Child & Adult ❑ No

Orthodontia Benefit Percentage:

Indemnity/In-Network ❑ 50% ❑ 60% ❑ Other _____%

Out-Network ❑ 50% ❑ 60% ❑ Other _____%

Orthodontia Lifetime Maximum: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Orthodontia 18-month waiting period*

18-month standard wait will apply with Open Enrollment.

*For groups with prior coverage, individual takeover credit will be given to those enrolling on the group's effective date. Individual effective date with prior carrier required.

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? ❑ Yes ❑ No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Voluntary Dental Insurance Product Addendum

Declaration

I understand that employees and their dependents who enroll for coverage after 31 days in which they were first eligible must satisfy waiting periods before they become eligible for certain types of services.

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner	Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Security Life Insurance Company of America
Voluntary Dual Option Dental Insurance Product Addendum

Group Information

Name of Employer: **Requested Effective Date:**

Number of Eligible Employees: **Number of Employees Enrolling:**

Do you currently have Group Dental Insurance? ❑ No ❑ Yes **Current Carrier:**
(If yes, attach a copy of the certificate and the latest billing statement.)

Number of COBRA Employees Enrolling: _____
(Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)

Open Enrollment Date: Annual open enrollment will occur during the month preceding the renewal date.

Termination of Coverage will occur on: ❑ the date the employee is no longer actively at work
❑ the end of the month in which the employee is no longer actively at work

Coverage Information

Class Description: **Weekly Work Hours Required for Eligibility:**

Dependent Dental: ❑ Yes ❑ No

Eligibility Waiting Period:
❑ _____ days from date of hire ❑ First of month following _____ days from date of hire

Do you want to include VSP Vision Access Discount Program at no charge? ❑ Yes ❑ No

Plan Information

❑ Indemnity ❑ PPO (where available)

SECTION I Complete for Dual **Low** Option benefit information

Benefit Percentages:

Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:
❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:
❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:
❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**
❑ $25 Calendar Year ❑ $50 Calendar Year ❑ $100 Lifetime ❑ Other $____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Voluntary Dual Option Dental Insurance Product Addendum

SECTION I Complete for Dual **Low** Option benefit information *(Continued)*

Basic Waiting Periods:

Under 20 Eligible Lives, a 6-month wait will apply to current employees* and new hires.

20+ Eligible Lives (select one):

- ❑ 6-month wait applies to current employees* and new hires
- ❑ 6-month wait waived for current employees; 6-month wait applies to new hires
- ❑ 6-month wait waived for current employees and new hires

6-month standard wait will apply with Open Enrollment.

Major Waiting Periods:

Under 50 Eligible Lives, a 12-month wait will apply to current employees* and new hires.

50+ Eligible Lives (select one):

Major Services

- ❑ 12-month wait applies to current employees* and new hires
- ❑ 12-month wait waived for current employees; 12-month wait applies to new hires
- ❑ 12-month wait waived for current employees and new hires

12-month standard wait will apply with Open Enrollment.

Orthodontia Option (available for groups with 50+ eligible lives):

❑ Yes, Child Only ❑ Yes, Child & Adult ❑ No

Orthodontia Benefit Percentage:

Indemnity/In-Network ❑ 50% ❑ 60% ❑ Other _____%

Out-Network ❑ 50% ❑ 60% ❑ Other _____%

Orthodontia Lifetime Maximum: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Orthodontia 18-month waiting period*

18-month standard wait will apply with Open Enrollment.

*For groups with prior coverage, individual takeover credit will be given to those enrolling on the group's effective date. Individual effective date with prior carrier required.

SECTION II Complete for Dual **High** Option benefit information

Benefit Percentages:

Indemnity/In-Network: Preventive _____% Basic _____% Major _____%

Out-of-Network: Preventive _____% Basic _____% Major _____%

Endodontics:

❑ Basic ❑ Major ❑ Not Covered

Non-Surgical Periodontal:

❑ Basic ❑ Major ❑ Not Covered

Complex Oral Surgery:

❑ Basic ❑ Major ❑ Not Covered

Surgical Periodontal:

❑ Basic ❑ Major ❑ Not Covered

Individual Deductible (for Basic & Major)**:**

❑ $25 Calendar Year ❑ $50 Calendar Year ❑ $100 Lifetime ❑ Other $_____

Annual Maximum Benefit: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Voluntary Dual Option Dental Insurance Product Addendum

SECTION II Complete for Dual **High** Option benefit information (*Continued)*

Basic Waiting Periods:

Under 20 Eligible Lives, a 6-month wait will apply to current employees* and new hires.

20+ Eligible Lives (select one):

- ❑ 6-month wait applies to current employees* and new hires
- ❑ 6-month wait waived for current employees; 6-month wait applies to new hires
- ❑ 6-month wait waived for current employees and new hires

6-month standard wait will apply with Open Enrollment.

Major Waiting Periods:

Under 50 Eligible Lives, a 12-month wait will apply to current employees* and new hires.

50+ Eligible Lives (select one):

Major Services

- ❑ 12-month wait applies to current employees* and new hires
- ❑ 12-month wait waived for current employees; 12-month wait applies to new hires
- ❑ 12-month wait waived for current employees and new hires

12-month standard wait will apply with Open Enrollment.

Orthodontia Option (available for groups with 50+ eligible lives):

❑ Yes, Child Only ❑ Yes, Child & Adult ❑ No

Orthodontia Benefit Percentage:

Indemnity/In-Network	❑ 50%	❑ 60%	❑ Other _____%
Out-Network	❑ 50%	❑ 60%	❑ Other _____%

Orthodontia Lifetime Maximum: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ Other $_____

Orthodontia 18-month waiting period*

18-month standard wait will apply with Open Enrollment.

*For groups with prior coverage, individual takeover credit will be given to those enrolling on the group's effective date. Individual effective date with prior carrier required.

SECTION III Additional Benefit Options

Cleanings: ❑ Standard — 1 routine cleaning *or* 1 periodontal maintenance every 6 months
❑ Buy-up Additional — 1 routine cleaning *and* 1 periodontal maintenance every 6 months

Implant Coverage (Major Only)**:** ❑ Yes ❑ No

Do Preventive expenses apply toward the annual maximum? ❑ Yes ❑ No

Voluntary Dual Option Dental Insurance Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? ❑ Yes ❑ No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

I understand that employees and their dependents who enroll for coverage after 31 days in which they were first eligible must satisfy waiting periods before they become eligible for certain types of services.

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner **Date**

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Dental Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[Not Available][October 1 – October 31]
[Work Hours Required for Eligibility	**Your** regularly scheduled work hours must be at least [30] hours per week.]
Waiting Period	For **your coverage**: [90] [days] [months] [For **your dependent coverage**: [90] [days] [months]] **[Coverage** will become effective on the first day of the month following the **waiting period** if all other requirements for **coverage** to become effective are satisfied.] [There will be no **waiting period** for employees who are **actively at work** and are part of the initial enrollment.]
Your Premium Contribution	**You** are [not] required to contribute towards the cost of **your coverage**. [**You** are [not] required to contribute towards the cost of **your dependent coverage**.]
[Dental Coverage	[[High] [Low] Option]]
Deductible	[Every **calendar year**, **you** must pay the first $[50] [for **you** and for each of **your covered dependents** up to$[150] per family] of Qualifying Dental Expenses for [Preventive] [and] [Basic] [and] [Major] Dental Expenses.] [The **deductible** for [Preventive][and][,] [Basic] [and Major] Dental Expenses is $0.] [**You** must pay the first $[100] of Qualifying Dental Expenses [for **you** and for each of **your covered dependents]** for [Preventive] [and] [Basic] [and] [Major] Dental Expenses during [their][your] lifetime while insured under the **policy**.]
Benefit Percentages	After **you** have satisfied the **deductible**, **we** will pay for Qualifying Dental Expenses up to the Maximum Benefit at the following percentages: [Preventive Dental Expenses: [100]% [Basic Dental Expenses: [80]%] [Major Dental Expenses: [50]%]] [During the first [12] months while **you** are continuously insured under the

policy:

Preventive Dental Expenses: [100]%
[Basic Dental Expenses: [80]%]
[Major Dental Expenses: [50]%]

From the [13th]month while **you** are continuously insured under the **policy**:

Preventive Dental Expenses: [100]%
[Basic Dental Expenses: [90]%]
[Major Dental Expenses: [60]%]]

[[For new employees,] **your** [High Option] **coverage** must be in effect for:

[1.] [[12 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period**, your** [High Option] **coverage** must be in effect for:

[1.] [[6 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for [Preventive Dental Expenses][, or][Basic Dental Expenses][or][Major Dental Expenses] during the first [12] months **your coverage** is in effect will be [$250]].

Maximum Benefit

The Maximum Benefit that **we** will pay in any **calendar year** is $[1,000] per person. The Maximum Benefit includes all payments made for [Preventive] [,] [and] [Basic] [and Major] Dental Expenses.

[Maximum Benefit Rollover

You [or **your covered dependents**] may be eligible to roll over to the next **calendar year** a portion of **your** unused Maximum Benefit. If benefits paid for **you** [or **your covered dependents**] do not exceed [$500] during the **calendar year**, excluding payments made for Orthodontic expenses, [$250] will roll over to the next **calendar year**. **Your** accumulated Maximum Benefit cannot exceed [$2,000]. [If **you** [or **your covered dependents**] are subject to the Late Enrollment Restriction, **you** [or **your covered dependents**] become eligible for the Maximum Benefit Rollover at the end of the Late Enrollment Restriction period.]]

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or

[Temporary Layoff – [Up to the end of the month that immediately follows the month in which your temporary layoff begins.] [Up to [3] months after **your** last day of **active work**.]]

Schedule of Benefits

other Leave of Absence	**Injury** or **Illness** – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act). Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).
[Dependent Dental Coverage	[Not] Included]
[Dependent Student Age Limit	[23] years]
[Orthodontic Benefit	Benefit Percentage: [50]% Lifetime Deductible: $[0] Lifetime Maximum Benefit: $[1,000] [Age Limit: Limited to **covered dependent children** under age 19] [**Covered dependent children**, under age 19:] [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].] [**You** and **your covered dependents**, age 19 and over:] [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].]]

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A “step-child” is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:
   a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
   b. primarily dependent upon **you** for support and maintenance;

and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy.**

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner.]**

Illness

Your medically determinable sickness, disease or pregnancy.

Injury

Your medically determinable bodily impairment caused by and resulting

Defined Terms

directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Treatment Plan

A report by **your dental practitioner**, submitted on a form acceptable to **us**, that includes:

1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and
2. a list of charges for each procedure; and
3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll after 31 days of **your eligibility date**.]

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll after 31 days of **your eligibility date**.]

[Actively at Work Requirement does not apply to retirees.]

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Dental Coverage – for you

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. [In the case of a late enrollment, the Late Enrollment Restriction will apply.] [**You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.]

[**You** may change plan options only one time. This one-time change must coincide with the plan anniversary date of **your covered employer's** dental insurance under the **policy**.]

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence.

[You will not be eligible to re-enroll if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

Dental Coverage – for you

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness,** or other leave of absence**,** and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period** or a late enrollment restriction. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence], on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the

Dental Coverage – for you

policy. Your Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

If **your covered employer** pays 100% of the cost of **your dependent coverage** under the **policy**, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your dependent coverage** under the **policy** or if **you** pay 100% of the cost, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 90 days from the moment of birth. To continue the **child's coverage** past the first 90 days, **you** must enroll the newborn within 90 days of the date the **child** is born.

Coverage for an adopted child will be effective from the date of the filing of a petition for adoption if **you** apply for **coverage** within 60 days after the filing of the petition for adoption. **Coverage** will begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the child.

[Dental Coverage – for your Dependents]

Eligibility Requirement for your Dependent Dental Coverage

You will be eligible for **dependent coverage** on the date **you** have satisfied the following:

1. **your coverage** is in effect;
2. **your eligible class** provides for **dependent coverage**;
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective. [If **you** make a late enrollment of a **dependent**, the Late Enrollment Restriction will apply.] [**You** can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

[Your dependents will not be eligible to re-enroll under the **policy** if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

[Late Enrollment Restriction

If **you** [or one of **your dependents]** enroll for **coverage** after the first 31 days in which **you** [or **your dependents]** were first eligible, any Major or Orthodontic Dental Expenses will not be considered Qualifying Dental Expenses until **coverage** for those expenses has been effective for 12 months. The maximum benefit that **we** will pay during this 12-month period for Preventive and Basic Dental Expenses will be limited to [$250].]

[Waiver of Dental Late Enrollment Restriction

You [or **your dependents**] will not be considered a late enrollment if **you** [or **your dependents**] lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** [or **your dependents]** were covered under the other group dental plan at the time of such loss of **coverage**; and enrollment is received by **us** within 31 days of termination under the prior group dental plan.

[Your child will not be considered a late enrollment if **your child** is enrolled within 31 days of their 3rd birthday.]]

Dental Benefit

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent]** [was][were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and

4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below.

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays, and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed

appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a

dependent.

3. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you [**or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [**or **your covered dependent]** for the longer period of time will pay before a plan insuring **you [**or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. [Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.]
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

[X-RAYS

1. [Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.]
2. [Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.]
3. [Periapical films: Limited to 4 films in any 12 consecutive months.]
4. [Occlusal films: Limited to 4 films in any 12 consecutive months.]
]

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. [Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive months for covered individuals age 15 and over; benefit includes scaling and polishing.]
2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES

Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.

c. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth .
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of

oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of

active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant ; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

[Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a

Description of Qualifying Dental Expenses

bridge. Temporary bridges older than 1 year are considered a permanent appliance.

2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.]

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).
4 Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9 . Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **your** participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Dental Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[Not Available][October 1 – October 31]
[Work Hours Required for Eligibility	**Your** regularly scheduled work hours must be at least [30] hours per week.]
Waiting Period	For **your coverage**: [90] [days] [months] [For **your dependent coverage**: [90] [days] [months]] [**Coverage** will become effective on the first day of the month following the **waiting period** if all other requirements for **coverage** to become effective are satisfied.] [There will be no **waiting period** for employees who are **actively at work** and are part of the initial enrollment.]
Your Premium Contribution	**You** are [not] required to contribute towards the cost of **your coverage**. [**You** are [not] required to contribute towards the cost of **your dependent coverage**.]
[Dental Coverage	[[High] [Low] Option]]
Deductible	[Every **calendar year**, **you** must pay the first $[50] [for **you** and for each of **your covered dependents** up to $[150] per family] of Qualifying Dental Expenses for [Preventive] [and] [Basic] [and][Major] Dental Expenses.] [The **deductible** for [Preventive][and][,] [Basic] [and Major] Dental Expenses is $0.] [**You** must pay the first $[100] of Qualifying Dental Expenses [for **you** and for each of **your covered dependents]** for [Preventive] [and] [Basic] [and] [Major] Dental Expenses during [their][your] lifetime while insured under the **policy**.]

Schedule of Benefits

Benefit Percentages

After **you** have satisfied the **deductible**, **we** will pay for Qualifying Dental Expenses up to the Maximum Benefit at the following percentages:

[

	Participating Dentists	Non-Participating Dentists
Preventive Dental Expenses:	[100]%	[100]%
[Basic Dental Expenses:	[90]%	[80]%]
[Major Dental Expenses:	[60]%	[50]%]]

[During the first [12] months while **you** are continuously insured under the **policy**:

	Participating Dentists	Non-Participating Dentists
Preventive Dental Expenses:	[100]%	[100]%
[Basic Dental Expenses:	[90]%	[80]%]
[Major Dental Expenses:	[60]%	[50]%]

From the [13th]month while **you** are continuously insured under the **policy**:

	Participating Dentists	Non-Participating Dentists
Preventive Dental Expenses:	[100]%	[100]%
[Basic Dental Expenses:	[90]%	[80]%]
[Major Dental Expenses:	[60]%	[50]%]]

[[For new employees,] **your** [High Option] **coverage** must be in effect for:

[1.] [[12 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period**, your** [High Option] **coverage** must be in effect for:

[1.] [[6 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for [Preventive Dental Expenses][, or][Basic Dental Expenses][or][Major Dental Expenses] during the first [12] months **your coverage** is in effect will be [$250]].

Maximum Benefit

The Maximum Benefit that **we** will pay in any **calendar year** is $[1,000] per person. The Maximum Benefit includes all payments made for [Preventive][,] [and] [Basic] [and Major] Dental Expenses.

[Maximum Benefit Rollover

You [or **your covered dependents**] may be eligible to roll over to the next **calendar year** a portion of **your** unused Maximum Benefit. If benefits paid for **you** [or **your covered dependents**] do not exceed [$500] during the **calendar year**, excluding payments made for Orthodontic expenses, [$250] will roll over to the next **calendar year**. **Your** accumulated Maximum Benefit cannot

Schedule of Benefits

	exceed [$2,000].] [If **you** [or **your covered dependents**] are subject to the Late Enrollment Restriction, **you** [or **your covered dependents**] become eligible for the Maximum Benefit Rollover at the end of the Late Enrollment Restriction period.]
Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	[Temporary Layoff – [Up to the end of the month that immediately follows the month in which your temporary layoff begins.] [Up to [3] months after **your** last day of **active work.**]] **Injury** or **Illness** – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act). Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).
[Dependent Dental Coverage	[Not] Included]
[Dependent Student Age Limit	[23] years]
[Orthodontic Benefit	Benefit Percentage: **Participating Dentists**: [60]% **Non-Participating Dentists:** [40]% Lifetime Deductible: [$0] Lifetime Maximum Benefit: $[1,000] [Age Limit: Limited to **covered dependent children** under age 19] [**Covered dependent children**, under age 19:] [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].] [**You** and **your covered dependents**, age 19 and over:] [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy]** before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.]

Schedule of Benefits

[If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].]]

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A “step-child” is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you.**

[Covered Dependent

A **dependent** with **coverage]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:
   a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];

b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy.**

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner**.]

Illness

Your medically determinable sickness, disease or pregnancy.

Defined Terms

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Non-Participating Dentist

A **dental practitioner** who has not entered into a written agreement with a preferred provider organization that **we** have contracted with.

Participating Dentist

A **dental practitioner** who has entered into a written agreement with a preferred provider organization that **we** have contracted with to provide dental services.

Treatment Plan

A report by **your dental practitioner**, submitted on a form acceptable to **us,** that includes:

1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and
2. a list of charges for each procedure; and
3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll after 31 days of **your eligibility date**.]

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll after 31 days of **your eligibility date**.]

[Actively at Work Requirement does not apply to retirees.]

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work

You must be **actively at work** for **your coverage** or any **new coverage** to

Dental Coverage – for you

Requirement

become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. [In the case of a late enrollment, the Late Enrollment Restriction will apply.] [**You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.]

[**You** may change plan options only one time. This one-time change must coincide with the plan anniversary date of **your covered employer's** dental insurance under the **policy**.]

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date][the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence.

[You will not be eligible to re-enroll if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period** or a late enrollment restriction. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence], on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the **policy. Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

If **your covered employer** pays 100% of the cost of **your dependent coverage** under the **policy**, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your dependent coverage** under the **policy** or if **you** pay 100% of the cost, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 90 days from the moment of birth. To continue the **child's coverage** past the first 90 days, **you** must enroll the newborn within 90 days of the date the **child** is born.

Coverage for an adopted child will be effective from the date of the filing of a petition for adoption if **you** apply for **coverage** within 60 days after the filing of the petition for adoption. **Coverage** will begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the child.

[Dental Coverage – for your Dependents]

Eligibility Requirement for your Dependent Dental Coverage

You will be eligible for **dependent coverage** on the date **you** have satisfied the following:

1. **your coverage** is in effect;
2. **your eligible class** provides for **dependent coverage**;
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective. [If **you** make a late enrollment of a **dependent**, the Late Enrollment Restriction will apply.] [**You** can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

[Your dependents will not be eligible to re-enroll under the **policy** if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

IMPORTANT NOTICE: To maximize **your** benefits, **you** should see a **participating dentist**. Benefits may be lower if **you** incur Qualifying Dental Expenses from a **non-participating dentist.**

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

[Late Enrollment Restriction

If **you** [or one of **your dependents]** enroll for **coverage** after the first 31 days in which **you** [or **your dependents]** were first eligible, any Major or Orthodontic Dental Expenses will not be considered Qualifying Dental Expenses until **coverage** for those expenses has been effective for 12 months. The maximum benefit that **we** will pay during this 12-month period for Preventive and Basic Dental Expenses will be limited to [$250].]

[Waiver Of Dental Late Enrollment Restriction

You [or **your dependents**] will not be considered a late enrollment if **you** [or **your dependents**] lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** [or **your dependents]** were covered under the other group dental plan at the time of such loss of **coverage**; and enrollment is received by **us** within 31 days of

termination under the prior group dental plan.

[Your child will not be considered a late enrollment if **your child** is enrolled within 31 days of their 3rd birthday.]]

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance** for **non-participating dentists** or the fee schedule amount for **participating dentists**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent] [**was][were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and
4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below**.**

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you** [or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a **dependent**.
3. a plan insuring **you** [or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you** [or **your covered dependent]** for the longer period of time will pay before a plan insuring **you** [or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

Dental Benefit

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. [Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.]
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

[X-RAYS

1. [Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.]
2. [Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.]
3. [Periapical films: Limited to 4 films in any 12 consecutive months.]
4. [Occlusal films: Limited to 4 films in any 12 consecutive months.]]

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. [Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive months for covered individuals age 15 and over; benefit includes scaling and polishing.]
2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES
Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one

restorative procedure.

c. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

   a. Alveoloplasty, per quadrant.
   b. Removal of exostosis.
   c. Excision of hyperplastic tissue.
   d. Excision of pericoronal gingival per tooth.
   e. Excision of tooth related cyst, tumor or neoplasm.
   f. Incision and drainage of abscess.
   g. Oroantral fistula closure.
   h. Frenulectomy or frenuloplasty.
   i. Sialolithotomy for removal of salivary calculus.
   j. Closure of salivary fistula.
   k. Sialodochoplasty.
   l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
   m. Surgical excision of lesions.
   n. Vestibuloplasty.
   o. Surgical exposure of impacted or unerupted tooth to aid eruption.
   p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated Crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy and frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.

b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

[Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your**

plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.]

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.
2. Services furnished primarily for cosmetic reasons, including but not limited to:
    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **you**r participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment excess to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Voluntary Dental Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[October 1 – October 31]
[Work Hours Required for Eligibility	**Your** regularly scheduled work hours must be at least [30] hours per week.]
Waiting Period	For **your coverage**: [90] [days] [months] [For **your dependent coverage**: [90] [days] [months]] **[Coverage** will become effective on the first day of the month following the **waiting period** if all other requirements for **coverage** to become effective are satisfied.] [There will be no **waiting period** for employees who are **actively at work** and are part of the initial enrollment.]
Your Premium Contribution	**You** are required to pay the entire premium for **your coverage**.
[Dental Coverage	[[High] [Low] Option]]
Deductible	[Every **calendar year**, **you** must pay the first $[50] [for **you** and for each of **your covered dependents** up to$[150] per family] of Qualifying Dental Expenses for [Preventive][and][Basic][and][Major] Dental Expenses.] [The **deductible** for [Preventive][and][,] [Basic] [and Major] Dental Expenses is $0.] [**You** must pay the first $[100] of Qualifying Dental Expenses [for **you** and for each of **your covered dependents]** for [Preventive] [and] [Basic] [and][Major] Dental Expenses during [their][your] lifetime while insured under the **policy**.]
Benefit Percentages	After **you** have satisfied the **deductible**, **we** will pay for Qualifying Dental Expenses up to the Maximum Benefit at the following percentages: [Preventive Dental Expenses: [100]%

Schedule of Benefits

[Basic Dental Expenses: [80]%]
[Major Dental Expenses: [50]%]]

[During the first [12] months while **you** are continuously insured under the **policy**:

Preventive Dental Expenses: [100]%
[Basic Dental Expenses: [80]%]
[Major Dental Expenses: [50]%]

From the [13th]month while **you** are continuously insured under the **policy**:

Preventive Dental Expenses: [100]%
[Basic Dental Expenses: [90]%]
[Major Dental Expenses: [60]%]]

[[For new employees,] **your** [High Option] **coverage** must be in effect for:

[1.] [[12 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period**, your** [High Option] **coverage** must be in effect for:

[1.] [[6 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for [Preventive Dental Expenses][, or][Basic Dental Expenses][or][Major Dental Expenses] during the first [12] months **your coverage** is in effect will be [$250]].

Maximum Benefit

The Maximum Benefit that **we** will pay in any **calendar year** is $[1,000] per person. The Maximum Benefit includes all payments made for [Preventive] [,] [and] [Basic] [and Major] Dental Expenses.

[Maximum Benefit Rollover

You [or **your covered dependents**] may be eligible to roll over to the next **calendar year** a portion of **your** unused Maximum Benefit. If benefits paid for **you** [or **your covered dependents**] do not exceed [$500] during the **calendar year**, excluding payments made for Orthodontic expenses, [$250] will roll over to the next **calendar year**. **Your** accumulated Maximum Benefit cannot exceed [$2,000].]

Schedule of Benefits

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	[Temporary Layoff – [Up to the end of the month that immediately follows the month in which your temporary layoff begins.] [Up to [3] months after **your** last day of **active work.**]] **Injury** or **Illness** – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act). Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).
[Dependent Dental Coverage	[Not] Included]
[Dependent Student Age Limit	[23] years]
[Orthodontic Benefit	Benefit Percentage: [50]% Lifetime Deductible: $[0] Lifetime Maximum Benefit: $[1,000] [Age Limit: Limited to **covered dependent children** under age 19] [**Covered dependent children**, under age 19:] [[For new employees,] **your coverage** must be in effect for [18 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [18 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [18] months **your coverage** is in effect will be [$250].] [**You** and **your covered dependents**, age 19 and over:] [[For new employees,] **your coverage** must be in effect for [18 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [18 months] before Orthodontic Dental Expenses will be

considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [18] months **your coverage** is in effect will be [$250].]]

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage.]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:

   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:

   a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the

Dependent Student Age Limit] [age [19]];
b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy**.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner**.]

Illness

Your medically determinable sickness, disease or pregnancy.

Defined Terms

Injury	**Your** medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.
Maximum Allowance	The allowance as determined by **us** to be an appropriate fee for the services or supplies provided. In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.
New Coverage	**New coverage** is either: 1. a newly acquired **coverage** under the **policy**; or 2. an increase in the amount of an in force **coverage**.
Treatment Plan	A report by **your dental practitioner**, submitted on a form acceptable to **us**, that includes: 1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and 2. a list of charges for each procedure; and 3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

Your coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the first day of the month following the Open Enrollment Period shown on the Schedule of Benefits.

Eligibility Requirement

If **you** enroll within 31 days after **you** become eligible, **your coverage** will become effective on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. **You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

Dental Coverage – for you

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **you** will be eligible to re-enroll one time.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

Dental Coverage – for you

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence**]**, on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the **policy. Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

Your dependent coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage; and
3. **you** have paid the first premium for that **dependent** when due.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** enroll **your dependent** more than 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 90 days from the moment of birth. To continue the **child's coverage** past the first 90 days, **you** must enroll the newborn within 90 days of the date the **child** is born or during the Open Enrollment Period.

Coverage for an adopted child will be effective from the date of the filing of a petition for adoption if **you** apply for **coverage** within 60 days after the filing of the petition for adoption. **Coverage** will begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the child.

Eligibility Requirement for your Dependent Dental Coverage

If **you** enroll **your dependents** within 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent** ; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.

[Dental Coverage – for your Dependents]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **your dependent** will be eligible to re-enroll one time.

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment

continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent]** [was][were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and
4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below.

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was

effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Dental Benefit

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a **dependent**.
3. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you [**or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [**or **your covered dependent]** for the longer period of time will pay before a plan insuring **you [**or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. [Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.]
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

[X-RAYS

1. [Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.]
2. [Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.]
3. [Periapical films: Limited to 4 films in any 12 consecutive months.]
4. [Occlusal films: Limited to 4 films in any 12 consecutive months.]]

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. [Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive

months for covered individuals age 15 and over; benefit includes scaling and polishing.]

2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES

Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    c. Pin Retention: Only in conjunction with amalgam or

composite resin restorations and only 1 per tooth.

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of

services rendered.

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)]

and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

[Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

Description of Qualifying Dental Expenses

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.]

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children,** including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

Limitations and Exclusions

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **your** participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Voluntary Dental Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[October 1 – October 31]
[Work Hours Required for Eligibility	**Your** regularly scheduled work hours must be at least [30] hours per week.]
Waiting Period	For **your coverage**: [90] [days] [months] [For **your dependent coverage**: [90] [days] [months] [**Coverage** will become effective on the first day of the month following the **waiting period** if all other requirements for **coverage** to become effective are satisfied.] [There will be no **waiting period** for employees who are **actively at work** and are part of the initial enrollment.]
Your Premium Contribution	**You** are required to pay the entire premium for **your coverage**
[Dental Coverage	[[High] [Low] Option]]
Deductible	[Every **calendar year**, **you** must pay the first $[50] [for **you** and for each of **your covered dependents** up to $[150] per family] of Qualifying Dental Expenses for [Preventive] [and] [Basic] [and][Major] Dental Expenses.] [The **deductible** for [Preventive][and][,] [Basic] [and Major] Dental Expenses is $0.] [**You** must pay the first $[100] of Qualifying Dental Expenses [for **you** and for each of **your covered dependents]** for [Preventive] [and] [Basic] [and] [Major] Dental Expenses during [their][your] lifetime while insured under the **policy**.]

Schedule of Benefits

Benefit Percentages

After **you** have satisfied the **deductible**, **we** will pay for Qualifying Dental Expenses up to the Maximum Benefit at the following percentages:

[

	Participating Dentists	Non-Participating Dentists
Preventive Dental Expenses:	[100]%	[100]%
[Basic Dental Expenses:	[90]%	[80]%]
[Major Dental Expenses:	[60]%	[50]%]]

[During the first [12] months while **you** are continuously insured under the **policy**:

	Participating Dentists	Non-Participating Dentists
Preventive Dental Expenses:	[100]%	[100]%
[Basic Dental Expenses:	[90]%	[80]%]
[Major Dental Expenses:	[60]%	[50]%]

From the [13th]month while **you** are continuously insured under the **policy**:

	Participating Dentists	Non-Participating Dentists
Preventive Dental Expenses:	[100]%	[100]%
[Basic Dental Expenses:	[90]%	[80]%]
[Major Dental Expenses:	[60]%	[50]%]]

[[For new employees,] **your** [High Option] **coverage** must be in effect for:

[1.] [[12 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period**, your** [High Option] **coverage** must be in effect for:

[1.] [[6 months] before Basic Dental Expenses will be considered Qualifying Dental Expenses][.][; and]
[2.] [12 months] before Major Dental Expenses will be considered Qualifying Dental Expenses.]

[If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for [Preventive Dental Expenses][, or][Basic Dental Expenses][or][Major Dental Expenses] during the first [12] months **your coverage** is in effect will be [$250]].

Maximum Benefit

The Maximum Benefit that **we** will pay in any **calendar year** is $[1,000] per person. The Maximum Benefit includes all payments made for [Preventive][,] [and] [Basic] [and Major] Dental Expenses.

[Maximum Benefit Rollover

You [or **your covered dependents**] may be eligible to roll over to the next **calendar year** a portion of **your** unused Maximum Benefit. If benefits paid for **you** [or **your covered dependents**] do not exceed [$500] during the **calendar year**, excluding payments made for Orthodontic expenses, [$250] will roll over to the next **calendar year**. **Your** accumulated Maximum Benefit cannot

Schedule of Benefits

	exceed [$2,000].]
Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	[Temporary Layoff – [Up to the end of the month that immediately follows the month in which your temporary layoff begins.] [Up to [3] months after **your** last day of **active work.**]] **Injury** or **Illness** – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act). Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).
[Dependent Dental Coverage	[Not] Included]
[Dependent Student Age Limit	[23] years]
[Orthodontic Benefit	Benefit Percentage: **Participating Dentists**: [60]% **Non-Participating Dentists:** [40]% Lifetime Deductible: [$0] Lifetime Maximum Benefit: $[1,000] [Age Limit: Limited to **covered dependent children** under age 19] [**Covered dependent children**, under age 19:] [[For new employees,] **your coverage** must be in effect for [18 months] [from the effective date of **your covered employer's** dental insurance under the **policy**.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [18 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [18] months **your coverage** is in effect will be [$250].] [**You** and **your covered dependents**, age 19 and over:] [[For new employees,] **your coverage** must be in effect for [18 months] [from the effective date of **your covered employer's** dental insurance under the **policy**.] [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [18 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum

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benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [18] months **your coverage** is in effect will be [$250].]]

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage.]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:

   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:

   a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the

Dependent Student Age Limit] [age [19]];
b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy**.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner**.]

Illness

Your medically determinable sickness, disease or pregnancy.

Defined Terms

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Non-Participating Dentist

A **dental practitioner** who has not entered into a written agreement with a preferred provider organization that **we** have contracted with.

Participating Dentist

A **dental practitioner** who has entered into a written agreement with a preferred provider organization that **we** have contracted with to provide dental services.

Treatment Plan

A report by **your dental practitioner**, submitted on a form acceptable to **us**, that includes:

1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and
2. a list of charges for each procedure; and
3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

Your coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the first day of the month following the Open Enrollment Period shown on the Schedule of Benefits.

Eligibility Requirement

If **you** enroll within 31 days after **you** become eligible, **your coverage** will become effective on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your** coverage to become effective. **You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness, or other Leave of Absence.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **you** will be eligible to re-enroll one time.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness, or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

Dental Coverage – for you

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence], on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the **policy. Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

Your dependent coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage; and
3. **you** have paid the first premium for that **dependent** when due.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** enroll **your dependent** more than 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 90 days from the moment of birth. To continue the **child's coverage** past the first 90 days, **you** must enroll the newborn within 90 days of the date the **child** is born or during the Open Enrollment Period.

Coverage for an adopted child will be effective from the date of the filing of a petition for adoption if **you** apply for **coverage** within 60 days after the filing of the petition for adoption. **Coverage** will begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the child.

Eligibility Requirement for your Dependent Dental Coverage

If **you** enroll **your dependents** within 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent** ; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.

[Dental Coverage – for your Dependents]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **your dependent** will be eligible to re-enroll one time.

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

IMPORTANT NOTICE: To maximize **your** benefits, **you** should see a **participating dentist**. Benefits may be lower if **you** incur Qualifying Dental Expenses from a **non-participating dentist.**

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance** for **non-participating dentists** or the fee schedule amount for **participating dentists**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent]** [was] [were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and
4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below.

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the

prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Dental Benefit

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a **dependent**.
3. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you [**or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [**or **your covered dependent]** for the longer period of time will pay before a plan insuring **you [**or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. [Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.]
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

[X-RAYS

1. [Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.]
2. [Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.]
3. [Periapical films: Limited to 4 films in any 12 consecutive months.]
4. [Occlusal films: Limited to 4 films in any 12 consecutive months.]]

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. [Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive

months for covered individuals age 15 and over; benefit includes scaling and polishing.]

2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES

Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    c. Pin Retention: Only in conjunction with amalgam or

composite resin restorations and only 1 per tooth.

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of

services rendered.

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)]

and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

[Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

Description of Qualifying Dental Expenses

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.]

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children,** including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **your** participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/09/2011

Comments:

Attachments:

AR Certificate of Readability - Dental.pdf

AR Certificate of Compliance - Dental.pdf

AR Consumer Notice.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/09/2011
Bypass Reason:	N/A - Application is being filed for approval.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	03/09/2011

Comments:

Attachment:

Dental SOV Nav Final - revised.pdf

Security Life
INSURANCE COMPANY OF AMERICA

1808 Colonial Village Lane
Suite 102
Lancaster, PA 17601
(800) 233-0307
www.securitylifeinsurance.com

Arkansas Certificate of Readability

I hereby certify, that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Score
GP2010MP	42.5
GP2010MC	40.2
GP2010DBP	40.3
GP2010DPBP	40.0
GP2010VDBP	40.2
GP2010VDPBP	40.0

Bryan V. Anderson

Bryan Anderson, Executive VP - Operations

March 3, 2011
Date

Security Life
INSURANCE COMPANY OF AMERICA

1808 Colonial Village Lane
Suite 102
Lancaster, PA 17601
(800) 233-0307
www.securitylifeinsurance.com

Arkansas Certificate of Compliance

I hereby certify that Security Life Insurance Company of America will adhere to and comply with the following:

1. Pursuant to Rule and Regulation 49, the Life and Health Guaranty Notice will accompany every policy issued in the State of Arkansas; and
2. This submission meets the provisions of Rule and Regulation 19, as well as all applicable requirements of the Department; and
3. Pursuant to ACA 23-79-138 and Bulletin 11-88, the Arkansas Consumer Information Notice will accompany every policy issued in the State of Arkansas.

Bryan V. Anderson

Bryan Anderson, Executive VP - Operations

March 3, 2011
Date

ARKANSAS CONSUMER INFORMATION NOTICE

If we at Security Life Insurance Company of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: 1-800-852-5494 or (501) 371-2640

Statement of Variability

Form number – GP2010DSB

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder on the application
1	Coverage Effective Date	Original effective date of group dental contract.
1	Plan Effective Date	Effective date of current group dental coverage.
1	Open Enrollment Period	Either "Not Available" or a date range will be included based on the selection by the policyholder on the application.
1	Work Hours Required for Eligibility	Hours variable will range from [15-40] hours
1	Waiting Period	Day range [0-365] or month range [0-24] 1st variable statement is included if there is dependent coverage 2nd variable statement is included if the effective date is the first of the month after the waiting period 3rd variable statement is included standard, optional to remove at policyholder request.
1	Your Premium Contribution	[Not] variable depending on whether or not you are required to contribute to coverage Second sentence included if there is dependent coverage.
1	Dental Coverage	Description of plan. Section will be included with Dual Option plans.
1	Deductible	1st variable section prints if there is an Annual Deductible 2nd variable section prints if there is no Deductible 3rd variable section prints if there is a Lifetime Deductible [Preventive][Basic]and [Major] included if that coverage is being provided Individual Calendar Year Deductible Range [$0-$150] Family Calendar Year Deductible Range [$0-$450] Lifetime Deductible Range [$0-$250]
1	Benefit Percentages	1st variable section included standardly. Preventive Dental Expenses range [50-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 2nd variable section, optional. This would print rather than the 1st variable section Month Range [6-36] Preventive Dental Expenses range [50-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% Month Range [7 – 37]

		Preventive Dental Expenses range [50-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 3rd variable section included if there is a waiting period Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement 4th and 5th section, one or the other is included if there is open enrollment and waits at open enrollment Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement Month range [6-24 months] Maximum payment amount [$100 - $1000]
2	Maximum Benefit	Maximum Benefit range [$500 - $5000] [Preventive][Basic][Major] included if that coverage is being provided
3	Maximum Benefit Rollover	Section will be included if selected by the policyholder, as there is a cost associated with this option. [or your covered dependents] included if there is dependent coverage. Benefits range [$250-$2500] Rollover range [$125-$1250] Accumulated Maximum Benefit [$500-$2500]
3	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff and applicable statement will be included if selected by policyholder to match their HR policy. Months variable will range from [0-12]
3	Dependent Dental Coverage	Section will be included if there is dependent coverage or not included.
3	Dependent Student Age Limit	Section will be included if there is a Dependent Student Age Limit selected by policyholder Age will range from [22-30]
4	Orthodontic Benefit	Section included if Orthodontia Benefits selected on the application If coverage is for children only, the [Age Limit] variable will print If coverage is for children and adults – [Covered dependent children, under age 19:] and [You and your covered dependents, age 19 and over:] will print If there is a waiting period, the following variable will print – [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] If there is Open Enrollment and a wait either one or the other following variables will be included –

		[If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] OR [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].] Benefit percentage range [20%-100%] Lifetime Deductible range [$0-$250] Lifetime Maximum Benefit range [$500-$5000] Month range [6-36 months] Maximum Benefit for Orthodontic Dental Expenses [$100-$1000]

Form number – GP2010DBP

Defined Terms

Page #	Provision	Variables
1	Covered Dependent	Section will be included if there is dependent coverage.
1	Dental Practitioner	[domestic partner] included standard, optional to remove at policyholder request.
1	Dependent	Section will be included if there is dependent coverage. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
2	Domestic Partner	Section included standard, optional to remove at policyholder request.

Dental Coverage – for you

4	Effective Date of your Dental Coverage	1st variable statement included if there is open enrollment. 2nd variable statement included if there is not open enrollment 3rd variable statement included if there is retiree coverage.
5	Enrollment Requirement	1st variable statement prints if there is no open enrollment 2nd variable statement prints if there is open enrollment 3rd variable statement prints for dual option only.
5	Termination of your Dental Coverage	#5 - one statement will be included and one not included based on policyholder selection on the application. Temporary Layoff will be included if requested by policyholder to match their HR policy. Variable paragraph prints standard but optional to remove if requested.

6	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff will be included if selected by policyholder.
6	Continuity of Coverage	Section included standard, but is optional to remove at the request of the policyholder. Variable statements will be included based upon policyholder HR policy

Dental Coverage – for your Dependents

8	Dental Coverage – for your Dependents (entire section)	Variable section will be included if there is Dependent coverage.
8	Effective Date of your Dependent Dental Coverage	1st variable statement will be included if there is not open enrollment 2nd variable statement will be included if there is open enrollment.
9	Enrollment Requirement for your Dependent Dental Coverage	1st variable statement prints if there is no open enrollment 2nd variable statement prints if there is open enrollment
9	Termination of your Dependent Dental Coverage	Variable paragraph prints standard but optional to remove if requested.

Dental Benefit

10	Benefit Payment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
10	Late Enrollment Restriction	Variable section will be included if there is no open enrollment. Dependent variables included if there is dependent coverage. Maximum Benefit Amount range [$100-$1000]
10	Waiver of Dental Late Enrollment Restriction	Variable section will be included if Late Enrollment Restriction is included. Variable statements regarding dependent coverage will be included if there is dependent coverage.
10-11	Qualifying Dental Expenses	Variable statement regarding dependent coverage will be included if there is dependent coverage. Orthodontic variables will be included if the contract includes orthodontic benefits
11-12	Continuity of Treatment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits
12-13	Extension of Benefits	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits
13-14	Coordination of Benefits	Variable statements will be included if there is dependent coverage.

Description of Qualifying Dental Expenses

15-22	Description of Qualifying Dental Expenses	Variable provisions and statements will be included based on policyholder selection, to create coverage requested Inlays/Onlays/Crowns – Number of years range [5-10] Prosthodontic Services – Number of years range [5-10]

Limitations and Exclusions

23-24	Limitations and Exclusions	1h. Variable statement will be included standard, unless requested to be removed by policyholder 6. Variable statement standard unless implant coverage was purchased.

Claim Provisions

26	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
26	Recovery and Subrogation	Variable statement will be included if there is dependent coverage.

Form number – GP2010DPSB

Schedule of Benefits

Page #	**Provision**	**Variables**
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Original effective date of group dental contract.
1	Plan Effective Date	Effective date of current group dental coverage.
1	Open Enrollment Period	Either "Not Available" or a date range will be included based on the selection by the policyholder on the application.
1	Work Hours Required for Eligibility	Hours variable will range from [15-40] hours
1	Waiting Period	Day variable will range from [0-365] or will be listed by month and range from [0-24]. 1st variable statement is included if there is dependent coverage 2nd variable statement is included if the effective date is the first of the month after the waiting period 3rd variable statement is included standard, optional to remove at policyholder request.
1	Your Premium Contribution	[Not] variable depending on whether or not you are required to contribute to coverage Second sentence included if there is dependent coverage.
1	Dental Coverage	Description of plan. Section will be included with Dual Option plans.
1	Deductible	1st variable section prints if there is an Annual Deductible 2nd variable section prints if there is no Deductible 3rd variable section prints if there is a Lifetime Deductible [Preventive][Basic]and [Major] included if that coverage is being provided Individual Calendar Year Deductible Range [$0-$150] Family Calendar Year Deductible Range [$0-$450] Lifetime Deductible Range [$0-$250]

2	Benefit Percentages	1st variable section included standard. Preventive Dental Expenses range [50-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 2nd variable section, optional. This would print rather than the 1st variable section Month Range [6-36] Preventive Dental Expenses range [50-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% Month Range [7 – 37] Preventive Dental Expenses range [50-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 3rd variable section included if there is a waiting period Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement 4th and 5th section, one or the other is included if there is open enrollment and waits at open enrollment Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement Month range [6-24 months] Maximum payment amount [$100 - $1000]
2	Maximum Benefit	Maximum Benefit range [$500 - $5000] [Preventive][Basic][Major] included if that coverage is being provided
3	Maximum Benefit Rollover	Section will be included if selected by the policyholder, as there is a cost associated with this option. [or your covered dependents] included if there is dependent coverage. Benefits range [$250-$2500] Rollover range [$125-$1250] Accumulated Maximum Benefit [$500-$2500]
3	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff and applicable statement will be included if selected by policyholder to match their HR policy. Months variable will range from [0-12]
3	Dependent Dental Coverage	Section will be included if there is dependent coverage or not included.
3	Dependent Student Age Limit	Section will be included if there is a Dependent Student Age Limit selected by policyholder Age will range from [22-30]
4	Orthodontic Benefit	Section included if Orthodontia Benefits selected on the

		application If coverage is for children only, the [Age Limit] variable will print If coverage is for children and adults – [Covered dependent children, under age 19:] and [You and your covered dependents, age 19 and over:] will print If there is a waiting period, the following variable will print – [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] If there is Open Enrollment and a wait either one or the other following variables will be included – [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] OR [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].] Benefit percentage range [20%-100%] Lifetime Deductible range [$0-$100] Lifetime Maximum Benefit range [$500-$5000] Month range [6-24 months] Maximum Benefit for Orthodontic Dental Expenses [$100-$1000]

Form number – GP2010DPBP

Defined Terms

Page #	Provision	Variables
1	Covered Dependent	Section will be included if there is dependent coverage
1	Dental Practitioner	[domestic partner] included standard, optional to remove at policyholder request.
1	Dependent	Section will be included if selected by policyholder. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent

		student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
2	Domestic Partner	Section included standard, optional to remove at policyholder request.

Dental Coverage – for you

4	Effective Date of your Dental Coverage	1st variable statement included if there is open enrollment. 2nd variable statement included if there is not open enrollment 3rd variable statement included if there is retiree coverage.
5	Enrollment Requirement	1st variable statement prints if there is no open enrollment 2nd variable statement prints if there is open enrollment 3rd variable statement prints for dual option only.
5	Termination of your Dental Coverage	#5 - one statement will be included and one not included based on policyholder selection on the application. Temporary Layoff will be included if requested by policyholder to match their HR policy. Variable paragraph prints standard but optional to remove if requested.
5	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff will be included if selected by policyholder.
6	Continuity of Coverage	Section included standard, but is optional to remove at the request of the policyholder. Variable statements will be included based upon policyholder HR policy

Dental Coverage – for your Dependents

7	Dental Coverage – for your Dependents (entire section)	Variable section will be included if there is Dependent coverage.
7	Effective Date of your Dependent Dental Coverage	1st variable statement will be included if there is not open enrollment 2nd variable statement will be included if there is open enrollment.
8	Enrollment Requirement for your Dependent Dental Coverage	1st variable statement prints if there is no open enrollment 2nd variable statement prints if there is open enrollment
8	Termination of your Dependent Dental Coverage	Variable paragraph prints standard but optional to remove if requested.

Dental Benefit

9	Benefit Payment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
9	Late Enrollment Restriction	Variable section will be included if there is no open enrollment. Dependent variables included if there is dependent coverage.

		Maximum Benefit Amount range [$100-$1000]
9	Waiver of Dental Late Enrollment Restriction	Variable section will be included if Late Enrollment Restriction is included. Variable statements regarding dependent coverage will be included if there is dependent coverage.
10	Qualifying Dental Expenses	Variable statement regarding dependent coverage will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
10-11	Continuity of Treatment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits
11-12	Extension of Benefits	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits
12-13	Coordination of Benefits	Variable statement will be included if there is dependent coverage.

Description of Qualifying Dental Expenses

14-21	Description of Qualifying Dental Expenses	Variable provisions and statements will be included based on policyholder selection, to create coverage requested Inlays/Onlays/Crowns – Number of years range [5-10] Prosthodontic Services – Number of years range [5-10]

Limitations and Exclusions

22-23	Limitations and Exclusions	1h. Variable statement will be included standard, unless requested to be removed by policyholder 6. Variable statement standard unless implant coverage was purchased.

Claim Provisions

25	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
25	Recovery and Subrogation	Variable statement will be included if there is dependent coverage.

Form number – GP2010VDSB

Schedule of Benefits Schedule of Benefits

Page #	**Provision**	**Variables**
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Original effective date of group dental contract.
1	Plan Effective Date	Effective date of current group dental coverage.
1	Open Enrollment Period	Variable statements will include a date range.
1	Work Hours Required for Eligibility	Section will be included based on policyholder selection. Hours variable will range from [15-40] hours

1	Waiting Period	Day range [0-365] or month range [0-24] 1st variable statement is included if there is dependent coverage 2nd variable statement is included if the effective date is the first of the month after the waiting period 3rd variable statement is included standard, optional to remove at policyholder request.
1	Dental Coverage	Description of plan. Section will be included with Dual Option plans.
1	Deductible	1st variable section prints if there is an Annual Deductible 2nd variable section prints if there is no Deductible 3rd variable section prints if there is a Lifetime Deductible [Preventive][Basic]and [Major] included if that coverage is being provided Individual Calendar Year Deductible Range [$0-$150] Family Calendar Year Deductible Range [$0-$450] Lifetime Deductible Range [$0-$250]
1 – 2	Benefit Percentages	1st variable section included standardly. Preventive Dental Expenses range [30-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 2nd variable section, optional. This would print rather than the 1st variable section Month Range [6-36] Preventive Dental Expenses range [30-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% Month Range [7 – 37] Preventive Dental Expenses range [30-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 3rd variable section included if there is a waiting period Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement 4th and 5th section, one or the other is included if there is open enrollment and waits at open enrollment Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement Month range [6-24 months] Maximum payment amount [$100 - $1000]
2	Maximum Benefit	Maximum Benefit range [$500 - $5000] [Preventive][Basic][Major] included if that coverage is being provided

2	Maximum Benefit Rollover	Section will be included if selected by the policyholder, as there is a cost associated with this option. [or your covered dependents] included if there is dependent coverage. Benefits range [$250-$2500] Rollover range [$125-$1250] Accumulated Maximum Benefit [$500-$2500]
3	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff and applicable statement will be included if selected by policyholder to match their HR policy. Months variable will range from [0-12]
3	Dependent Dental Coverage	Section will be included if there is dependent coverage or not included.
3	Dependent Student Age Limit	Section will be included if there is a Dependent Student Age Limit selected by policyholder Age will range from [22-30]
3	Orthodontic Benefit	Section included if Orthodontia Benefits selected on the application If coverage is for children only, the [Age Limit] variable will print If coverage is for children and adults – [Covered dependent children, under age 19:] and [You and your covered dependents, age 19 and over:] will print If there is a waiting period, the following variable will print – [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] If there is Open Enrollment and a wait either one or the other following variables will be included – [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] OR [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].] Benefit percentage range [20%-100%] Lifetime Deductible range [$0-$100] Lifetime Maximum Benefit range [$500-$5000] Month range [6-24 months] Maximum Benefit for Orthodontic Dental Expenses [$100-$1000]

Form number – GP2010VDBP

Defined Terms

Page #	Provision	Variables
1	Covered Dependent	Section will be included if there is dependent coverage.
1	Dental Practitioner	[domestic partner] included standard, optional to remove at policyholder request.
1	Dependent	Section will be included if selected by policyholder. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
2	Domestic Partner	Section included standard, optional to remove at policyholder request.

Dental Coverage – for you

4-5	Termination of your Dental Coverage	#5 - one statement will be included and one not included based on policyholder selection on the application. Temporary Layoff will be included if requested by policyholder to match their HR policy.
5	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff will be included if selected by policyholder.
6	Continuity of Coverage	Section included standard, but is optional to remove at the request of the policyholder. Variable statements will be included based upon policyholder HR policy

Dental Coverage – for your Dependents

7	Dental Coverage – for your Dependents (entire section)	Variable section will be included if there is Dependent coverage.
8	Termination of your Dependent Dental Coverage	Variable paragraph prints standard but optional to remove if requested.

Dental Benefit

9	Benefit Payment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
9-10	Qualifying Dental Expenses	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
10-11	Continuity of Treatment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract

		includes orthodontic benefits
11	Extension of Benefits	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits
12-13	Coordination of Benefits	Variable statement will be included if there is dependent coverage.

Description of Qualifying Dental Expenses

14-21	Description of Qualifying Dental Expenses	Variable provisions and statements will be included based on policyholder selection, to create coverage requested Inlays/Onlays/Crowns – Number of years range [5-10] Prosthodontic Services – Number of years range [5-10]

Limitations and Exclusions

22-23	Limitations and Exclusions	1h. Variable statement will be included standard, unless requested to be removed by policyholder 6. Variable statement standard unless implant coverage was purchased.

Claim Provisions

25	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
25	Recovery and Subrogation	Variable statement will be included if there is dependent coverage.

Form number – GP2010VDPSB

Schedule of Benefits Schedule of Benefits

Page #	**Provision**	**Variables**
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Original effective date of group dental contract.
1	Plan Effective Date	Effective date of current group dental coverage.
1	Open Enrollment Period	Variable statement will include a date range.
1	Work Hours Required for Eligibility	Section will be included based on policyholder selection. Hours variable will range from [15-40] hours
1	Waiting Period	Day range [0-365] or month range [0-24] 1st variable statement is included if there is dependent coverage 2nd variable statement is included if the effective date is the first of the month after the waiting period 3rd variable statement is included standard, optional to remove at policyholder request.
1	Dental Coverage	Description of plan. Section will be included with Dual Option plans.
1	Deductible	1st variable section prints if there is an Annual Deductible 2nd variable section prints if there is no Deductible 3rd variable section prints if there is a Lifetime Deductible

		[Preventive][Basic]and [Major] included if that coverage is being provided Individual Calendar Year Deductible Range [$0-$150] Family Calendar Year Deductible Range [$0-$450] Lifetime Deductible Range [$0-$250]
2	Benefit Percentages	1st variable section included standardly. Preventive Dental Expenses range [30-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 2nd variable section, optional. This would print rather than the 1st variable section Month Range [6-36] Preventive Dental Expenses range [30-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% Month Range [7 – 37] Preventive Dental Expenses range [30-100]% Basic Dental Expenses range [0-100]% Major Dental Expenses range [0-100]% 3rd variable section included if there is a waiting period Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement 4th and 5th section, one or the other is included if there is open enrollment and waits at open enrollment Month range [3-24 months] for Basic statement Month range [6-36 months] for Major statement Month range [6-24 months] Maximum payment amount [$100 - $1000]
2	Maximum Benefit	Maximum Benefit range [$500 - $5000] [Preventive][Basic][Major] included if that coverage is being provided
3	Maximum Benefit Rollover	Section will be included if selected by the policyholder, as there is a cost associated with this option. [or your covered dependents] included if there is dependent coverage. Benefits range [$250-$2500] Rollover range [$125-$1250] Accumulated Maximum Benefit [$500-$2500]
3	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff and applicable statement will be included if selected by policyholder to match their HR policy. Months variable will range from [0-12]
3	Dependent Dental Coverage	Section will be included if there is dependent coverage or not included.

3	Dependent Student Age Limit	Section will be included if there is a Dependent Student Age Limit selected by policyholder Age will range from [22-30]
4	Orthodontic Benefit	Section included if Orthodontia Benefits selected on the application If coverage is for children only, the [Age Limit] variable will print If coverage is for children and adults – [Covered dependent children, under age 19:] and [You and your covered dependents, age 19 and over:] will print If there is a waiting period, the following variable will print – [[For new employees,] **your coverage** must be in effect for [12 months] [from the effective date of **your covered employer's** dental insurance under the **policy**] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] If there is Open Enrollment and a wait either one or the other following variables will be included – [If **you** enroll for **coverage** during the Open Enrollment Period, **your coverage** must be in effect for [12 months] before Orthodontic Dental Expenses will be considered Qualifying Dental Expenses.] OR [If **you** enroll for **coverage** during the Open Enrollment Period, the maximum benefit **we** will pay for **you** [or one of **your covered dependents]** for Orthodontic Dental Expenses during the first [12] months **your coverage** is in effect will be [$250].] Benefit percentage range [20%-100%] Lifetime Deductible range [$0-$100] Lifetime Maximum Benefit range [$500-$5000] Month range [6-24 months] Maximum Benefit for Orthodontic Dental Expenses [$100-$

]

Form number – GP2010VDPBP

Defined Terms

Page #	Provision	Variables
1	Covered Dependent	Section will be included if there is dependent coverage.
1	Dental Practitioner	[domestic partner] included standard, optional to remove at policyholder request.
1	Dependent	Section will be included if selected by policyholder. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent

		student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
2	Domestic Partner	Section included standard, optional to remove at policyholder request.

Dental Coverage – for you

5	Termination of your Dental Coverage	#5 - one statement will be included and one not included based on policyholder selection on the application. Temporary Layoff will be included if requested by policyholder to match their HR policy.
5	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff will be included if selected by policyholder.
6	Continuity of Coverage	Section included standard, but is optional to remove at the request of the policyholder. Variable statements will be included based upon policyholder HR policy

Dental Coverage – for your Dependents

7	Dental Coverage – for your Dependents (entire section)	Variable section will be included if there is Dependent coverage.
8	Termination of your Dependent Dental Coverage	Variable paragraph prints standard but optional to remove if requested.

Dental Benefit

9	Benefit Payment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
9-10	Qualifying Dental Expenses	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
10-11	Continuity of Treatment	Variable statement will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
11	Extension of Benefits	Variable statements will be included if there is dependent coverage. Orthodontic variable will be included if the contract includes orthodontic benefits.
12-13	Coordination of Benefits	Variable statement will be included if there is dependent coverage.

Description of Qualifying Dental Expenses

14-21	Description of Qualifying Dental Expenses	Variable provisions and statements will be included based on policyholder selection, to create coverage requested Inlays/Onlays/Crowns – Number of years range [5-10] Prosthodontic Services – Number of years range [5-10]

Limitations and Exclusions

22-23	Limitations and Exclusions	1h. Variable statement will be included standard, unless requested to be removed by policyholder 6. Variable statement standard unless implant coverage was purchased.

Claim Provisions

25	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
25	Recovery and Subrogation	Variable statement will be included if there is dependent coverage.

SERFF Tracking Number:	*SLIA-127053875*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	*48165*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Premier Choice - Dental*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/03/2011	Form	Voluntary Dental Benefit Provisions	03/09/2011	GP2010VDBP.pdf (Superceded)
03/03/2011	Form	Voluntary PPO Benefit Provisions	03/09/2011	GP2010VDPBP.pdf (Superceded)
03/03/2011	Form	Dental Benefit Provisions	03/09/2011	GP2010DBP.pdf (Superceded)
03/03/2011	Form	Dental PPO Benefit Provisions	03/09/2011	GP2010DPBP.pdf (Superceded)

Voluntary Dental Insurance

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is a child **you** have assumed legal obligation for total or partial support in anticipation of adoption regardless of whether a final adoption order is issued. This includes a child place with **you** for the purpose of adoption. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage.]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:

   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:

a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity within 31 days after the **child** reaches age [19], and subsequently as **we** may require, but not more frequently than annually after the 2 year period following the date **coverage** on the **dependent child** would otherwise have terminated.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy**.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Defined Terms

Unless otherwise noted, all references to spouse include **domestic partner**.]

Illness

Your medically determinable sickness, disease or pregnancy.

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Treatment Plan

A report by **your dental practitioner**, submitted on a form acceptable to **us**, that includes:

1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and
2. a list of charges for each procedure; and
3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

Your coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the first day of the month following the Open Enrollment Period shown on the Schedule of Benefits.

Eligibility Requirement

If **you** enroll within 31 days after **you** become eligible, **your coverage** will become effective on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. **You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

Dental Coverage – for you

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **you** will be eligible to re-enroll one time.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

Dental Coverage – for you

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence**]**, on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the **policy. Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

Your dependent coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage; and
3. **you** have paid the first premium for that **dependent** when due.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** enroll **your dependent** more than 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 31 days from the moment of birth. To continue the **child's coverage** past the first 31 days, **you** must enroll the newborn within 31 days of the date the **child** is born or during the Open Enrollment Period.

Eligibility Requirement for your Dependent Dental Coverage

If **you** enroll **your dependents** within 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent** ; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.

[Dental Coverage – for your Dependents]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **your dependent** will be eligible to re-enroll one time.

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment

continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent]** [was][were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and
4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below.

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was

effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Dental Benefit

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a **dependent**.
3. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you [**or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [**or **your covered dependent]** for the longer period of time will pay before a plan insuring **you [**or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

X-RAYS

1. Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.
2. Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.
3. Periapical films: Limited to 4 films in any 12 consecutive months.
4. Occlusal films: Limited to 4 films in any 12 consecutive months.

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive months for covered individuals age 15 and over; benefit includes scaling and

polishing.
2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES

Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    c. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

Description of Qualifying Dental Expenses

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

Description of Qualifying Dental Expenses

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root

planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a

permanent appliance.

2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children,** including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).
2. Services furnished primarily for cosmetic reasons, including but not limited to:
    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **your** participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Voluntary Dental Insurance

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is a child **you** have assumed legal obligation for total or partial support in anticipation of adoption regardless of whether a final adoption order is issued. This includes a child place with **you** for the purpose of adoption. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage.]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:

   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:

a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity within 31 days after the **child** reaches age [19], and subsequently as **we** may require, but not more frequently than annually after the 2 year period following the date **coverage** on the **dependent child** would otherwise have terminated.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy**.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Defined Terms

Unless otherwise noted, all references to spouse include **domestic partner**.]

Illness

Your medically determinable sickness, disease or pregnancy.

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Non-Participating Dentist

A **dental practitioner** who has not entered into a written agreement with a preferred provider organization that **we** have contracted with.

Participating Dentist

A **dental practitioner** who has entered into a written agreement with a preferred provider organization that **we** have contracted with to provide dental services.

Treatment Plan

A report by **your dental practitioner**, submitted on a form acceptable to **us**, that includes:

1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and
2. a list of charges for each procedure; and
3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

Your coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the first day of the month following the Open Enrollment Period shown on the Schedule of Benefits.

Eligibility Requirement

If **you** enroll within 31 days after **you** become eligible, **your coverage** will become effective on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your** coverage to become effective. **You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

Dental Coverage – for you

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness, or other Leave of Absence.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **you** will be eligible to re-enroll one time.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness, or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

Dental Coverage – for you

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence], on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the **policy. Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

Your dependent coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage; and
3. **you** have paid the first premium for that **dependent** when due.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** enroll **your dependent** more than 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 31 days from the moment of birth. To continue the **child's coverage** past the first 31 days, **you** must enroll the newborn within 31 days of the date the **child** is born or during the Open Enrollment Period.

Eligibility Requirement for your Dependent Dental Coverage

If **you** enroll **your dependents** within 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent** ; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.

[Dental Coverage – for your Dependents]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **your dependent** will be eligible to re-enroll one time.

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

IMPORTANT NOTICE: To maximize **your** benefits, **you** should see a **participating dentist**. Benefits may be lower if **you** incur Qualifying Dental Expenses from a **non-participating dentist.**

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance** for **non-participating dentists** or the fee schedule amount for **participating dentists**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent]** [was] [were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and
4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below.

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the

prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Dental Benefit

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a **dependent**.
3. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you [**or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [**or **your covered dependent]** for the longer period of time will pay before a plan insuring **you [**or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

X-RAYS

1. Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.
2. Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.
3. Periapical films: Limited to 4 films in any 12 consecutive months.
4. Occlusal films: Limited to 4 films in any 12 consecutive months.

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive months for covered individuals age 15 and over; benefit includes scaling and

polishing.
2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES

Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    c. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

Description of Qualifying Dental Expenses

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

Description of Qualifying Dental Expenses

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root

planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a

permanent appliance.

2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:

    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children,** including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).

2. Services furnished primarily for cosmetic reasons, including but not limited to:

    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.

3. Charges for any appliance or service that is used to:

    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).

4 Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.

5. Occlusal, athletic, or night guards.

. 6. [Implantology and related services; implants and all related procedures, including removal of implants.]

7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **your** participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Dental Insurance

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is a child **you** have assumed legal obligation for total or partial support in anticipation of adoption regardless of whether a final adoption order is issued. This includes a child placed with **you** for the purpose of adoption**.** An adopted child will be subject to the same conditions as a natural child.

A “step-child” is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:
   a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining

the
Dependent Student Age Limit] [age [19]];

b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity within 31 days after the **child** reaches age [19], and subsequently as **we** may require, but not more frequently than annually after the 2 year period following the date **coverage** on the **dependent child** would otherwise have terminated.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy.**

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner.]**

Defined Terms

Illness	**Your** medically determinable sickness, disease or pregnancy.
Injury	**Your** medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.
Maximum Allowance	The allowance as determined by **us** to be an appropriate fee for the services or supplies provided. In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.
New Coverage	**New coverage** is either: 1. a newly acquired **coverage** under the **policy**; or 2. an increase in the amount of an in force **coverage**.
Treatment Plan	A report by **your dental practitioner**, submitted on a form acceptable to **us**, that includes: 1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and 2. a list of charges for each procedure; and 3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll after 31 days of **your eligibility date**.]

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll after 31 days of **your eligibility date**.]

[Actively at Work Requirement does not apply to retirees.]

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Dental Coverage – for you

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. [In the case of a late enrollment, the Late Enrollment Restriction will apply.] [**You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.]

[**You** may change plan options only one time. This one-time change must coincide with the plan anniversary date of **your covered employer's** dental insurance under the **policy**.]

Termination of your Dental Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence.

[You will not be eligible to re-enroll if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

Dental Coverage – for you

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness,** or other leave of absence**,** and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period** or a late enrollment restriction. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence], on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the

Dental Coverage – for you

policy. Your Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

If **your covered employer** pays 100% of the cost of **your dependent coverage** under the **policy**, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your dependent coverage** under the **policy** or if **you** pay 100% of the cost, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 31 days from the moment of birth. To continue the **child's coverage** past the first 31 days, **you** must enroll the newborn within 31 days of the date the **child** is born.

Eligibility Requirement for your Dependent Dental Coverage

You will be eligible for **dependent coverage** on the date **you** have satisfied the following:

1. **your coverage** is in effect;

[Dental Coverage – for your Dependents]

2. **your eligible class** provides for **dependent coverage**;
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective. [If **you** make a late enrollment of a **dependent**, the Late Enrollment Restriction will apply.] [**You** can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

[Your dependents will not be eligible to re-enroll under the **policy** if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

[Late Enrollment Restriction

If **you** [or one of **your dependents]** enroll for **coverage** after the first 31 days in which **you** [or **your dependents]** were first eligible, any Major or Orthodontic Dental Expenses will not be considered Qualifying Dental Expenses until **coverage** for those expenses has been effective for 12 months. The maximum benefit that **we** will pay during this 12-month period for Preventive and Basic Dental Expenses will be limited to [$250].]

[Waiver of Dental Late Enrollment Restriction

You [or **your dependents**] will not be considered a late enrollment if **you** [or **your dependents**] lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** [or **your dependents]** were covered under the other group dental plan at the time of such loss of **coverage**; and enrollment is received by **us** within 31 days of termination under the prior group dental plan.

[Your child will not be considered a late enrollment if **your child** is enrolled within 31 days of their 3rd birthday.]]

Dental Benefit

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent]** [was][were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and

Dental Benefit

4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below.

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays, and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed

appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a

dependent.

3. a plan insuring **you [**or **your covered dependent]** as an employee is primary to a plan insuring **you [**or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [**or **your covered dependent]** for the longer period of time will pay before a plan insuring **you [**or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

X-RAYS

1. Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.
2. Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.
3. Periapical films: Limited to 4 films in any 12 consecutive months.
4. Occlusal films: Limited to 4 films in any 12 consecutive months.

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive months for covered individuals age 15 and over; benefit includes scaling and

polishing.
2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES

Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    c. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

Description of Qualifying Dental Expenses

BASIC ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.
2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

Description of Qualifying Dental Expenses

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth .
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy or frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant ; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits:

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.

Description of Qualifying Dental Expenses

2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:

    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians).

2. Services furnished primarily for cosmetic reasons, including but not limited to:

    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.

3. Charges for any appliance or service that is used to:

    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).

4 Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9 . Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **your** participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Dental Insurance

Defined Terms

Alternate Treatment

A less expensive procedure, service, or course of treatment that is customarily used to treat the dental problem and recognized by the dental profession to be appropriate according to broadly accepted standards of dental practice.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is a child **you** have assumed legal obligation for total or partial support in anticipation of adoption regardless of whether a final adoption order is issued. This includes a child placed with **you** for the purpose of adoption**.** An adopted child will be subject to the same conditions as a natural child.

A “step-child” is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you.**

[Covered Dependent

A **dependent** with **coverage]**

Deductible

The amount of Qualifying Dental Expenses that must be incurred before **we** pay any benefits.

Dental Practitioner

A dental assistant, dental hygienist, or dentist who is properly licensed or certified under the laws of the state in which he or she practices, and is operating within the scope of that license or certification.

A **dental practitioner** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];

[3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
   a. a full-time student at an accredited school;
   b. primarily dependent upon **you** for support and maintenance;
   c. not married; and
   d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;]

and

[4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:
   a. incapable of self-sustaining employment because of mental or

physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];

b. primarily dependent upon **you** for support and maintenance; and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity within 31 days after the **child** reaches age [19], and subsequently as **we** may require, but not more frequently than annually after the 2 year period following the date **coverage** on the **dependent child** would otherwise have terminated.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy.**

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:

    a. joint mortgage or joint tenancy on a residential lease;
    b. joint bank account;
    c. joint liabilities (e.g. credit cards or car loans);
    d. joint ownership of significant property (e.g. cars, land, etc.)
    e. naming of each other as primary beneficiary in wills or life insurance policies;
    f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
    g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner**.]

Defined Terms

Illness	**Your** medically determinable sickness, disease or pregnancy.
Injury	**Your** medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.
Maximum Allowance	The allowance as determined by **us** to be an appropriate fee for the services or supplies provided. In determining the **maximum allowance**, **we** may refer to various data regarding what similar **dental practitioners** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **dental practitioner's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.
New Coverage	**New coverage** is either: 1. a newly acquired **coverage** under the **policy**; or 2. an increase in the amount of an in force **coverage**.
Non-Participating Dentist	A **dental practitioner** who has not entered into a written agreement with a preferred provider organization that **we** have contracted with.
Participating Dentist	A **dental practitioner** who has entered into a written agreement with a preferred provider organization that **we** have contracted with to provide dental services.
Treatment Plan	A report by **your dental practitioner**, submitted on a form acceptable to **us,** that includes: 1. an itemized description of the recommended dental procedures using the American Dental Association codes and nomenclature; and 2. a list of charges for each procedure; and 3. the estimated length of treatment.

Dental Coverage – for you

Effective Date of your Dental Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll after 31 days of **your eligibility date**.]

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll after 31 days of **your eligibility date**.]

[Actively at Work Requirement does not apply to retirees.]

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work

You must be **actively at work** for **your coverage** or any **new coverage** to

Dental Coverage – for you

Requirement	become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day. **You** meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day. **You** will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.
Enrollment Requirement	**You** are required to enroll for **your coverage** to become effective. [In the case of a late enrollment, the Late Enrollment Restriction will apply.] [**You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group dental plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group dental plan.] [**You** may change plan options only one time. This one-time change must coincide with the plan anniversary date of **your covered employer's** dental insurance under the **policy**.]
Termination of your Dental Coverage	**Your coverage** will terminate at 11:59 p.m. on the earliest of the following dates: 1. the date the **policy** is terminated; or 2. the date **your eligible class** is no longer covered; or 3. the date **you** are no longer a member of an **eligible class**; or 4. the last date for which **you** make a required premium payment; or 5. [the date][the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence. **[You** will not be eligible to re-enroll if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]
Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits. If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits. While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness**, **injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period** or a late enrollment restriction. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group dental insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness]**[,][or][other leave of absence], on the effective date of the **policy, we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work.** During the Continuity of Coverage **we** will provide limited coverage under the **policy. Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy.**

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Dental Coverage – for your Dependents]

Effective Date of your Dependent Dental Coverage

If **your covered employer** pays 100% of the cost of **your dependent coverage** under the **policy**, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your dependent coverage** under the **policy** or if **you** pay 100% of the cost, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Dental Coverage; and
2. the Enrollment Requirement for your Dependent Dental Coverage.

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent** spouse **coverage** when the **child** is born, **we** will cover the **child** for the first 31 days from the moment of birth. To continue the **child's coverage** past the first 31 days, **you** must enroll the newborn within 31 days of the date the **child** is born.

Eligibility Requirement for your Dependent Dental Coverage

You will be eligible for **dependent coverage** on the date **you** have satisfied the following:

1. **your coverage** is in effect;

2. **your eligible class** provides for **dependent coverage**;
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Dental Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective. [If **you** make a late enrollment of a **dependent**, the Late Enrollment Restriction will apply.] [**You** can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group dental plan at the time of such loss of **coverage, your dependents** can enroll within 31 days of termination under the prior group dental plan.]

Termination of your Dependent Dental Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

[Your dependents will not be eligible to re-enroll under the **policy** if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.]

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.][; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Dental Benefit

Benefit Payment

IMPORTANT NOTICE: To maximize **your** benefits, **you** should see a **participating dentist**. Benefits may be lower if **you** incur Qualifying Dental Expenses from a **non-participating dentist.**

We will pay benefits for Qualifying Dental Expenses incurred by **you** [or **your covered dependents]** as shown in the Description of Qualifying Dental Expenses. All benefits are paid after **you** satisfy the **deductible** and will be based on the Benefit Percentages shown in the Schedule of Benefits. No one person can satisfy more than the individual **deductible**.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Dental Expenses and are subject to all other provisions of this **coverage**. All benefit maximums and limits, other than the orthodontic lifetime maximum (if applicable), are applied on a **calendar year** basis, except as otherwise indicated, regardless of when **coverage** is first effective.

[How Orthodontic Benefits are Paid:

Based on the total treatment fee, **we** will consider 25% to be the initial allowable amount. The remaining balance will be divided into equal monthly installments based on estimated months expected to be in active treatment.

The initial allowable amount will be payable upon receipt of proof from the provider that the orthodontic appliance has been placed. Monthly payments will be made upon receipt of proof from the provider that treatment has continued.

If orthodontic treatment commences prior to the date **your** Orthodontic Dental Expenses are considered Qualifying Dental Expenses, **our** allowable amount will be the monthly installments, as described above, for the remaining period of active treatment.

All benefits are considered at the Benefit Percentage level listed in the Schedule of Benefits and are subject to all other provisions of the **policy**.]

[Late Enrollment Restriction

If **you** [or one of **your dependents]** enroll for **coverage** after the first 31 days in which **you** [or **your dependents]** were first eligible, any Major or Orthodontic Dental Expenses will not be considered Qualifying Dental Expenses until **coverage** for those expenses has been effective for 12 months. The maximum benefit that **we** will pay during this 12-month period for Preventive and Basic Dental Expenses will be limited to [$250].]

[Waiver Of Dental Late Enrollment Restriction

You [or **your dependents**] will not be considered a late enrollment if **you** [or **your dependents**] lose **coverage** under another group dental plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** [or **your dependents]** were covered under the other group dental plan at the time of such loss of **coverage**; and enrollment is received by **us** within 31 days of

termination under the prior group dental plan.

[Your child will not be considered a late enrollment if **your child** is enrolled within 31 days of their 3rd birthday.]]

Qualifying Dental Expenses

Qualifying Dental Expenses are charges for dental supplies or services made on behalf of **you** [or **your covered dependents]** that are:

1. listed in the Description of Qualifying Dental Expenses;
2. incurred while **coverage** is effective, subject to the Extension of Benefits provision; and
3. recommended by a **dental practitioner** for treatment that commences after **coverage** becomes effective, except as provided in Continuity of Treatment and Limitations and Exclusions.

Qualifying Dental Expenses are incurred on the earliest of:

1. the date the service was performed; or
2. the date the treatment commences; or
3. the date the supply was purchased.

[For orthodontic treatment, Qualifying Dental Expenses are incurred on the date the appliance is placed and then monthly thereafter on the same day of the month as the placement date for as long as active or retentive treatment continues.]

Treatment commences as follows:

1. For prosthetic appliances: on the date the master impression is made; or
2. For a crown, bridge or cast restoration: on the date the tooth or teeth are prepared; or
3. For root canal therapy: on the date the canal is first opened [.] [; or]
4. [For orthodontic treatment: on the date the appliance is placed.]

The Qualifying Dental Expenses for dental procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance** for **non-participating dentists** or the fee schedule amount for **participating dentists**; or
3. the charge for an **alternate treatment**.

Dental procedures not listed as Qualifying Dental Expenses are not covered, except for procedures listed as **alternate treatment** or those **we** agree to accept as unlisted procedures.

Continuity of Treatment

If this **coverage** immediately replaces a prior group dental plan, **we** will pay benefits for the procedures listed below if:

1. treatment commenced before this **coverage** becomes effective; and
2. **you** [or **your covered dependent] [**was][were] insured by the prior plan immediately before the effective date of **coverage** under the **policy**; and
3. the procedure is listed as a Qualifying Dental Expense in the **policy**; and
4. **your** prior plan does not include an extension of benefits provision which will provide **coverage** for the procedures listed below**.**

Crowns, bridges or cast restorations will be payable if:

1. the tooth or teeth were prepared before the prior plan terminates; and
2. the procedures relate to a tooth or teeth extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Dentures (partial or full) will be payable if:

1. the master impression was made before the prior plan terminates; and
2. the teeth being replaced were extracted less than 6 months prior to the effective date of **coverage** under the **policy**.

Root Canal therapy will be payable if the pulp chamber was opened before the prior plan terminates.

[Orthodontic treatment will be payable if **coverage** for orthodontic treatment under the plan immediately preceding **your coverage** under the **policy** was effective on the date the active orthodontic appliance was first placed.]

Our benefit will be the lesser of the amount the prior plan would have paid or the benefit **we** would normally pay, minus the benefits actually paid by the prior plan.

If elected by the **covered employer, we** will reduce the **calendar year deductible** (if applicable) under the **policy** by the amount of covered charges applied to the **calendar year deductible** of the prior plan. If **we** apply the prior plan's **deductible**, **we** will also reduce the maximum payable under the **policy** by the benefits paid toward the maximum of the prior plan.

Extension of Benefits

After **coverage** terminates, **we** will continue to pay for Qualifying Dental Expenses for the procedures listed below, if:

1. treatment commenced prior to termination; and
2. the work is completed within 31 days after termination. [For Orthodontic Dental Expenses, **we** will continue to pay scheduled benefits through the end of the month in which **coverage** terminated.]

Treatment is deemed completed as follows:

1. For fixed bridges including resin bonded bridges, crowns, inlays and onlays: on the date that the appliance is permanently cemented in place; and
2. For root canal therapy: on the date the canals are permanently filled; and
3. For dentures and partial dentures: on the date that the final completed appliance is first inserted in the mouth. However, no denture or partial denture will be considered completed unless and until it is accepted by the patient.

If **you** [or **your covered dependents]** become eligible for group **coverage** that will pay any benefits for treatment covered by this provision, **we** will not pay any benefits for that treatment.

This provision does not apply if **your coverage** terminates because **you** fail to pay the required premium contribution when due.

Coordination of Benefits

If **you** [or **your covered dependents]** have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred practitioner organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing dental benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group; or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any dental care service or expense, including any **deductible** or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you** [or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a **dependent**.
3. a plan insuring **you** [or **your covered dependent]** as an employee is primary to a plan insuring **you** [or **your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you** [or **your covered dependent]** for the longer period of time will pay before a plan insuring **you** [or **your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR **CHILDREN** COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:

    a. not divorced; or
    b. not separated (whether or not they have ever been married to each other); or
    c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

    then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:

    a. the plan of the parent with primary physical custody;
    b. the plan of the spouse of the parent with primary physical custody;
    c. the plan of the non-custodial parent;
    d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

Dental Benefit

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Dental Expenses

Description of Qualifying Dental Expenses

PREDETERMINATION OF BENEFITS

It is recommended that a **treatment plan** be submitted when the total cost of Qualifying Dental Expenses for **you** [or **your covered dependents]** is expected to exceed $400. This should be submitted to **us** before the work is started. Diagnostic information, x-rays, treatment records and other pertinent information that would be required to support the need for the recommended treatment should be included.

We will review the **treatment plan** and estimate what **we** will pay. **We** will then send this information to **your dental practitioner**. If actual services submitted do not agree with the **treatment plan**, or if a **treatment plan** is not sent in, **we** will base **our** payment on treatment consistent with accepted standards of dental practice.

Predetermination of Benefits is not a guarantee of what **we** will pay. The estimated benefit payment is based on **your** current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or the **policy** may alter final payment.

Payment is subject to:

1. the work being done as proposed and while **coverage** is in effect; and
2. payments made by a primary carrier; and
3. all other terms and conditions of the **policy**.

Emergency dental care, oral examinations, dental x-rays and teeth cleaning as a part of a course of treatment may be performed before a **treatment plan** is submitted.

PREVENTIVE DENTAL EXPENSES

EVALUATIONS

1. Comprehensive or Periodic Oral Evaluation: Limited to 1 evaluation in any 6 consecutive months.
2. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

X-RAYS

1. Complete series / Panoramic: Limited to 1 panoramic film or complete series (including bitewing films) in any 60 consecutive months.
2. Bitewing films: Limited to 1 series consisting of no more than 4 films in any 12 consecutive months.
3. Periapical films: Limited to 4 films in any 12 consecutive months.
4. Occlusal films: Limited to 4 films in any 12 consecutive months.

ROUTINE DENTAL PROPHYLAXIS AND FLUORIDE TREATMENTS

1. Adult Prophylaxis: Limited to 1 treatment in any 6 consecutive months for covered individuals age 15 and over; benefit includes scaling and polishing.
2. [**Child** Prophylaxis: Limited to 1 treatment in any 6 consecutive months for **covered dependents** under age 15; benefit includes scaling and polishing.]
3. [Fluoride Treatments: Limited to 1 topical application in any 6 consecutive months for **covered dependents** under age 15.]

[SPACE MAINTAINERS

Limited to initial passive appliance for **covered dependents** under age 14 for missing primary teeth; includes all adjustments made within 6 months of installation; limited to fixed unilateral, fixed bilateral, and removable bilateral types. Recementation limited to 1 time in any 12 consecutive months.]

[SEALANTS

Limited to the occlusal surface of unrestored permanent molars for **covered dependents** under age 16; limited to 1 sealant treatment per tooth in any 48 consecutive months.]

[BASIC DENTAL EXPENSES

EVALUATIONS

1. Limited Oral Evaluation: Limited to 1 evaluation per **dental practitioner** in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the evaluation.
2. Diagnostic Consultation: Limited to 1 consultation (by a **dental practitioner** other than the one providing treatment) for each dental specialty in any 12 consecutive months and payable only if no other service (except x-rays) is rendered during the consultation.
3. [Emergency Palliative Treatment: Limited to 1 palliative treatment in any 6 consecutive months and payable only if no other service (except x-rays) is rendered.]

BASIC RESTORATIVE SERVICES
Insulating base and local anesthesia is considered an integral part of services rendered.

1. Fillings:

    a. Amalgam Restoration: Limited to 1 filling per tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.
    b. Composite Resin (Synthetic) Restoration: Limited to 1 filling per [anterior] tooth surface in any 24 consecutive months. Contiguous surfaces billed separately will be combined as one restorative procedure.

c. Pin Retention: Only in conjunction with amalgam or composite resin restorations and only 1 per tooth.

BASIC ORAL SURGERY
Local anesthesia and routine follow-up care are considered an integral part of basic oral surgery.

Extractions: Non-surgical extraction, 1 or more teeth.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

   a. Alveoloplasty, per quadrant.
   b. Removal of exostosis.
   c. Excision of hyperplastic tissue.
   d. Excision of pericoronal gingival per tooth.
   e. Excision of tooth related cyst, tumor or neoplasm.
   f. Incision and drainage of abscess.
   g. Oroantral fistula closure.
   h. Frenulectomy or frenuloplasty.
   i. Sialolithotomy for removal of salivary calculus.
   j. Closure of salivary fistula.
   k. Sialodochoplasty.
   l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
   m. Surgical excision of lesions.
   n. Vestibuloplasty.
   o. Surgical exposure of impacted or unerupted tooth to aid eruption.
   p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
b. Periodontal Maintenance: Limited to 1 treatment in any 6 consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

[BASIC PROSTHODONTIC SERVICES

Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

[OTHER BASIC SERVICES

General Anesthesia: Only when medically necessary in conjunction with a

covered complex oral surgery procedure.] **]**

[MAJOR DENTAL EXPENSES

MAJOR RESTORATIVE SERVICES

Laboratory fabricated restorations and crowns are covered only when needed because of extensive decay or fracture and only when the tooth cannot be restored with a direct placement restoration. Insulating base, temporization and associated gingival treatment are considered an integral part of services rendered.

[IMPLANTS

Implants, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implants, but not more than once in a 24 month period.

Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period, when needed to replace natural teeth that are lost while **you** are insured under this **coverage**.

Repair of implant supported prosthetics, but not more than once in a 24 month period.

Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current prosthetic device.]

INLAYS / ONLAYS / CROWNS

Inlay, onlay and crown replacements are payable only after [5] years from the date of initial insertion. Temporary inlays, temporary onlays and prefabricated crowns older than 1 year are considered a permanent appliance and are subject to the [5]-year replacement limitations.

1. Crowns: Acrylic with metal; Porcelain; Porcelain with metal; Full cast or ¾ cast metal, other than stainless steel; Cast post and core, in addition to crown but not a thimble coping; Steel post and composite or amalgam core, in addition to crown; Cast dowel pin, one-piece cast with crown, based on type of crown.
2. Prefabricated Crowns: only for a tooth fractured as a result of an accident; a permanent tooth[; or a primary tooth for a **covered dependent** under age 14]; limited to one prefabricated crown per lifetime of the tooth.
3. Labial Veneers: Covered as an **alternate treatment** to a crown when the tooth would have otherwise qualified for a crown.
4. Recementation: Considered part of original service if done within 1 year of initial placement.

[COMPLEX ORAL SURGERY

Local anesthesia and routine follow-up care are considered an integral part of oral surgery.

1. Complex Extractions: Surgical removal of erupted teeth, involving tissue flap and bone removal, removal of residual roots, or impacted teeth.

2. Other Surgical Procedures

    a. Alveoloplasty, per quadrant.
    b. Removal of exostosis.
    c. Excision of hyperplastic tissue.
    d. Excision of pericoronal gingival per tooth.
    e. Excision of tooth related cyst, tumor or neoplasm.
    f. Incision and drainage of abscess.
    g. Oroantral fistula closure.
    h. Frenulectomy and frenuloplasty.
    i. Sialolithotomy for removal of salivary calculus.
    j. Closure of salivary fistula.
    k. Sialodochoplasty.
    l. Maxillary sinusotomy for removal of tooth fragment or foreign body.
    m. Surgical excision of lesions.
    n. Vestibuloplasty.
    o. Surgical exposure of impacted or unerupted tooth to aid eruption.
    p. Biopsy and exam of tooth related oral tissue.]

[ENDODONTIC SERVICES

1. Root canal therapy: Non-vital, nerve-dead tooth; local anesthesia and routine follow-up care are considered an integral part of services rendered; limited to 1 root canal treatment per tooth in any 36 consecutive months.
2. Vital pulpotomy: Limited to primary teeth only.
3. Apexification: Therapeutic apical closure.
4. Apicoectomy and retrograde filling: As a separate procedure or in conjunction with other endodontic procedures; limited to 1 treatment per tooth in any 36 consecutive months.]

[PERIODONTAL SERVICES

Local anesthesia and routine follow-up care are considered an integral part of services rendered.

[1.] [Non-Surgical Services:

    a. Periodontal Scaling and Root Planing: As necessary for substantial bone and attachment loss evident on current periodontal charting and radiographs; limited to 1 treatment per quadrant in any 24 consecutive months.
    b. Periodontal Maintenance: Limited to 1 treatment in any 6

consecutive months [(replaces routine dental prophylaxis)] and only qualifying after 3 months from date of completion of active periodontal treatment, including scaling and root planing.]

[2.] [Surgical Services: Limited to 1 periodontal surgical service per quadrant in any 36 consecutive months.

a. Gingivectomy: Per quadrant; limited to less than 3 teeth.
b. Osseous Surgery: Per quadrant; benefit includes all necessary associated surgical procedures.
c. Mucogingival Surgery: Pedicle soft tissue graft; gingival flap procedure; guided tissue regeneration; free soft tissue graft.
d. Bone Replacement Grafts: Only when related to periodontal procedures.
e. Clinical Crown Lengthening: Benefit includes all necessary associated surgical procedures.]]

PROSTHODONTIC SERVICES

[Limited to services performed more than 12 months after initial insertion of appliance.

1. Denture Adjustments and Repairs: Adjustments**;** repairing acrylic dentures, no teeth damage; repairing acrylic dentures and replacing one or more broken teeth; Repairing metal dentures to the extent and nature of damage and type of materials involved; replacing one or more broken teeth, no other damage.
2. Denture Rebase: Limited to once per denture in any 36 consecutive months.
3. Denture Reline: Limited to once per denture in any 12 consecutive months.
4. Tissue Conditioning: Limited to a maximum of 2 treatments per arch in any 12 consecutive months.
5. Addition of Teeth to Partial Dentures: Limited to replace natural teeth lost under this **coverage**.
6. Crown/Bridge Repair: Limited to extent and nature of damage and type of materials involved.]

Bridge or denture replacements available only after [8] years from the date of initial installation. No benefits are payable for replacement of third molars or a portion of a tooth lost due to root amputation or hemisection.

Missing Tooth: If **you** [or **your covered dependents]** have lost one or more teeth prior to **your** effective date, **we** will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under the **policy**. **We** will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of **coverage** effective date if the **policy** immediately replaces a prior plan. Replacement of congenitally missing teeth is not covered under **your** plan unless **you** are replacing a current fixed bridge or denture. This

replacement is subject to contract replacement limits:

1. Fixed Bridges: Each abutment and each pontic makes up a unit of a bridge. Temporary bridges older than 1 year are considered a permanent appliance.
2. Dentures: Benefit includes all adjustments done by **dental practitioner** furnishing denture during first 6 months after installation. Temporary dentures older than 1 year are considered a permanent appliance.

[OTHER MAJOR SERVICES

General Anesthesia: Only when medically necessary in conjunction with a covered complex oral surgery procedure.] **]**

[ORTHODONTIC DENTAL EXPENSES

Benefit includes **treatment plan** for the correction of any existing malocclusion through the correction of malposed teeth, including diagnosis (with radiographs), extractions (to correct crowding), surgical access of an unerupted tooth, active treatment (including appliances) and retention treatment following active treatment. Replacement of lost, stolen, or broken appliances are not covered.]

Limitations and Exclusions

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
    a. not listed in the Description of Qualifying Dental Expenses;
    b. not prescribed by or performed by or under the direct supervision of a **dental practitioner**;
    c. not dentally necessary as determined by **us**;
    d. not meeting the accepted standards of dental practice;
    e. experimental in nature;
    f. that have a questionable prognosis;
    g. covered under any medical insurance policy; or
    h. performed by a member of **your** or **your** spouse's family (family includes parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.
2. Services furnished primarily for cosmetic reasons, including but not limited to:
    a. Specialized techniques, characterizing and personalizing prosthetic devices;
    b. making facings on prosthetic devices for any tooth in back of the second bicuspid; or
    c. replacements of restorations performed for cosmetic reasons.
3. Charges for any appliance or service that is used to:
    a. change vertical dimension;
    b. restore or maintain occlusion, except to the extent that the **policy** covers orthodontic treatment;
    c. splint or stabilize teeth for periodontal reasons; or
    d. treat disturbances of the temporomandibular joint (TMJ).
4. Charges for any service performed as a result of abrasion, attrition, bruxism, erosion or abfraction.
5. Occlusal, athletic, or night guards.
6. [Implantology and related services; implants and all related procedures, including removal of implants.]
7. Preventive root canal therapy.
8. Full mouth debridement.
9. Charges for any services that are considered to be an integral part of another service, such as pulp capping, surgical trays, or sutures.
10. Ridge preservation, augmentation, bone grafts and regeneration procedures performed in edentulous sites.
11. Overdentures or precision attachments.
12. Preparation and fitting of preformed dowel or post for root canal tooth; pulp cap either directly or indirectly.
13. Duplicate or temporary devices, appliances, and services except as listed as a qualifying expense.
14. Replacing a lost, stolen or missing appliance or prosthetic device.
15. Application of chemotherapeutic agents.

16. Oral hygiene, plaque control, diet instruction or infection control.
17. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
18. Non-emergency services performed outside the United States or Canada.
19. Treatment which is:

    a. due to an on-the-job or job-related **illness** or **injury**; or
    b. a condition for which benefits are payable by Workers' Compensation or similar laws, whether or not benefits are claimed.

20. Treatment for which no charge is made or for which **you** are not legally obligated to pay including, but not limited to, treatment (or charges made) by:

    a. **your covered employer**, labor union or similar group, in its dental or medical department or clinic;
    b. a facility owned or run by any government body; or
    c. any public program, except Medicaid, paid for or sponsored by any government body.

21. Telephone consultations, charges for failure to keep a scheduled appointment, X-ray copy fees, or charges for completion of a claim form.
22. Codes that are by report.
23. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
24. Treatment resulting from:

    a. **you**r participation in a war or an act of war, declared or undeclared;
    b. **your** attempting to commit, or committing, an assault or felony;
    c. **your** unlawful participation in a riot, rebellion, or insurrection; or
    d. an intentionally self-inflicted **injury** while sane or insane.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **dental practitioner** to that of another during the course of treatment, or if more than one **dental practitioner** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **dental practitioner** performed the service.
2. In all cases involving qualifying expenses in which the **dental practitioner** and **you** select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the qualifying expense concerned, payment under the plan will be based on the charge allowed for the lesser procedure.

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to $1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Claims Provisions

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment excess to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

If **your** [or **your covered dependent's]** claim appears to have resulted from an **injury** or **illness** that may be someone else's fault, any benefits otherwise due under the **policy** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.